advocare | Center for Specialized Gynecology

RECORDS RELEASE AUTHORIZATION TO RESPOND TO INQUIRIES

To: Dr. _____ , or to Records

Administrator of _____[hospital or medical facility]

Address:

_____

_____

I am the patient named below, and I have executed this form to authorize and direct you or your organization to release originals or copies of all medical records relating to me and to my treatment by you to:

Advocare Center for Specialized Gynecology
1930 Marlton Pike East, Executive Mews Suite S-93
Cherry Hill, NJ 08003
Phone (856) 424-8091
Fax (856) 424-0704

This instruction covers all complete history records in your possession concerning my illness and/or treatment during the period from _____ to _____ , or [ ] ALL RECORDS.

I have requested Advocare Center for Specialized Gynecology to assume responsibility for my care. I authorize you to immediately provide to Advocare Center for Specialized Gynecology any diagnosis, test results, or other medical information necessary for my safe and continued care pending delivery of such records. By my signature below I authorize you to rely upon an original signature or a facsimile signature, and release you from liability for furnishing information called for by this form to Advocare Center for Specialized Gynecology. Thank you for your prompt attention to this matter.

Name [print]: _____ Date of Birth: _____

Address: _____ Phone: _____

City, State, Zip: _____

Signature: _____ Today's Date: _____

Witness: _____

Please return the completed form to our office. Note that there may be a charge for copies per state Medical Society guidelines. If so, a staff member will contact you to review any charges.

Susan Kaufman, DO, FACOG • Jodi Benett, DO, FACOOG • Helen Gorlitsky, MD, FACOG • Faith Tiver-Foran, MSN, WHNP-BC