101 Holbrook Street
Danville, VA 24541
(434) 792-7765 – Phone
(434) 793-4061 – Fax

REQUEST FOR MEDICAL RECORDS

Released **TO/FROM**: OB-GYN ASSOCIATES OF DANVILLE, INC
101 HOLBROOK STREET
DANVILLE, VA 24541
Phone: (434) 792-7765 Fax: (434) 793-4061

Released **TO/FROM**: Facility Name:_____

Address: _____

Phone: _____ Fax: _____

Patient Name: _____

Date Of Birth: _____ **Social Security #**:_____

Information or Records Requested (**Specify**):_____

_____

I understand that I have the right to access my medical records in accordance with the law and the policies of OB-GYN Associates of Danville, Inc. I understand that I may be charged for copies of my medical records. I also understand that this authorization will expire 12 months from the date the authorization is signed.

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral health or mental services and treatment for alcohol and drug abuse.

I understand that OB-GYN Associates of Danville, Inc. has the right to deny me access to my records in certain circumstances in accordance with the law. If OB-GYN Associates of Danville, Inc. denies me access to my medical information, I understand it will provide me with the reasons for the denial in writing and describe whether I have the right to have a review of the denial performed by a licensed health care professional.

Please note that information disclosed pursuant to this request is no longer under the control of OB-GYN Associates of Danville, Inc. and may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Signature of Patient: _____ Date: _____

Patient Representative: _____ Date: _____

Relationship to Patient: _____