

Heather M. Metchick, M.D.
Coastal Women's Health

433 North Causeway
New Smyrna Beach, FL 32169

(386) 427-4441 tel
(386) 427-4494 fax

Medical Records Release Form from another provider
(To be used to provide us with your records from another provider)

Patient Name: _____ Soc. Sec. # _____

Address: _____ Date of Birth: _____

By signing this authorization, I authorize _____
to use and/or disclose certain protected health information (PHI) about me. I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed below by mail.

Please send my protected health information to the following location:

Heather M. Metchick, M.D.
Coastal Women's Health
433 North Causeway, New Smyrna Beach, FL 32169
(386) 427-4441 • Fax (386) 427-4494

The information will be used or disclosed for the following purpose:

My authorization extends or is limited to:

Records of my visits from 2007 to present unless otherwise specified.

Patient history

Progress notes

Diagnostic reports

Consultation reports

Statement of charges and payments

All of the above

Other: must specify _____

This authorization is given freely with the understanding that:

1. Any and all records, whether written or oral or in the electronic format, are confidential and cannot * be disclosed without my prior written authorization, except as provided by law.
2. A photocopy or fax of this authorization is as valid as the original.
3. I may revoke this authorization at any time, except where information has already been released.
4. Treatment, payment and operation of our business may not be conditioned upon this authorization.
5. The release of information authorized may be subject to re-disclosure by the recipient.

This authorization will expire on _____ .

Patient Signature [or parent, guardian or legal representative]:

Date