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### CONSENT FOR RELEASE OF MEDICAL INFORMATION

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

1. I hereby request and authorize West Ridge Obstetrics & Gynecology, LLP to:

- Release Information TO  Obtain Information FROM

2. Name of Provider / Facility \_\_\_\_\_  
Address \_\_\_\_\_  
Telephone \_\_\_\_\_ Contact Person \_\_\_\_\_

3. The PURPOSE of this release is: (check all that apply)

- Moving  Insurance Purpose  Transferring Care  Second Opinion  
 Personal Review  Other (please specify) \_\_\_\_\_

4. The FOLLOWING Protected Health Information (PHI) may be released: (please check one)

I consent to the release of **all medical records** including records, reports or tests concerning alcoholism and/or drug abuse or treatment information, sexually transmitted disease related and/or psychological or psychiatric treatment. I also understand that the release of information related to the diagnosis or treatment of HIV requires an additional authorization. (This release excludes any records transferred to West Ridge from previous care providers).

I consent to the release of **all medical records** with the following exceptions. (Specifically describe the information you do not wish to have released) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I consent to the release of **all medical records** relating to the following treatment or condition: \_\_\_\_\_  
\_\_\_\_\_

I consent to the release of **all medical records** from \_\_\_\_\_ date to \_\_\_\_\_ date.

5. **This authorization will automatically expire within one year from the date of signature.** I understand that I have the right to revoke this authorization in writing at any time, except where information has already been released in response to this authorization.

**NOTICE TO PATIENT:** For permanent records transfer, there is a fee of \$.50 per page for copying and administrative costs. This fee will not be charged to you unless the total copying cost exceeds \$5.00 and will not exceed a total charge of \$25.00. A statement will be mailed to you.

\_\_\_\_\_  
Signature of Patient/ Representative/ or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

**NOTICE TO RECIPIENT OF RECORDS:** This information has been disclosed to you from confidential records that are protected by law. State law prohibits you from making any future disclosures of this information without specific written authorization of the person to whom it pertains, or as otherwise permitted by Federal or State law.