AMY BRENNER, MD & ASSOCIATES

Medical Records Release Authorization

Patient Name_____DOB_____Social Security Number _____

Medical Records to be released From/To (please circle)
Amy Brenner MD & Associates
6413 Thornberry Ct.
Mason, Ohio 45040
Phone- 513-770-0787 Fax- 513-770-0144

Medical Records to be released From/To (please circle)

Name_____

Address_____City_____State_____

Phone_____FAX_____Email_____

Your privacy is very important to us and email is not our preferred way of communication. Please ask us about signing up for a secure online patient portal for a secure as a safe option of receiving your medical records.

Information to be released:

_____ Complete Patient Files _____ Lab Test Results _____ Practitioner's Notes
_____ Urodynamics _____ Surgical Notes _____Other

Reason for release:

_____ Personal Copy

_____Other

_____Transfer of health care provider. We are continually striving to improve our practice and how we care for patients. We welcome feedback on your experience. If you would please inform us as to the reason for your decision to change your care provider, we would greatly appreciate it.(Please list in area below.)

_____
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_____

□ I understand my medical records contain private information.
□ I understand by authorizing this release of health records, the health care provider providing the records is no longer responsible for the confidentiality of such records.
□I understand that I am unable to revoke authorization for the release of the records once they are released. I can revoke authorization for the future releases.
□ I understand fees MAY apply for the release of my records (i.e. entire chart).
□ Any charges accrued, as a result of the release of records, is the patient's sole responsibility.

Signature of Patient_____Date_____