

Volusia OB/GYN
500 Health Blvd
Daytona Beach, FL 32114
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REQUEST FOR RELEASE OF MEDICAL RECORDS

DATE REQUESTED

DATE COPIED/SENT

REASON FOR REQUEST: CHANGING DOCTOR / MOVING / REFERRAL / OTHER (CIRCLE ONE)

IF "OTHER" OR "CHANGING DOCTOR", PLEASE STATE REASON: _____

PATIENT NAME

SOCIAL SECURITY #

BIRTHDATE

PLEASE RELEASE RECORDS FROM:

Dr _____

Address _____

Phone # _____

FAX # _____

PLEASE SEND RECORDS TO:

IF I HAVE HAD A SCREENING TEST FOR THE HUMAN IMMUNODEFICIENCY VIRUS (HIV), I REQUEST THAT THOSE RESULTS BE INCLUDED WITH MY MEDICAL RECORDS.

_____ YES _____ NO PATIENT'S INITIALS: _____

PATIENT'S SIGNATURE: _____

PLEASE ALLOW US 3 - 4 BUSINESS DAYS TO PROCESS YOU REQUEST