PLEASE INCLUDE THIS FORM WHEN SENDING THE RECORDS!

Print Form

Medical Records Release Request

I, the undersigned, authorize _____ to release information from my medical record. This authorization includes release of information concerning treatment of psychiatric/psychological condition, drug and/or alcohol related conditions and HIV or AIDS related conditions. **Please release the following information:**

* Operative note and pathology report from a tubal sterilization performed on the approximated date of: _____

The purpose of this request is for continued medical care. I would appreciate having these records faxed to Dr. Richard Levin at 502-589-3842 or mailed to his office at:

Richard M. Levin, M.D., PSC.
One Medical Center Plaza
225 Abraham Flexner Way, Suite 501
Louisville, KY 40202

This authorization must be signed and dated, and may be revoked at any time except to the extent action has been taken prior to revocation. Revocation must be made in writing. This authorization will expire on _____ . I hereby state that I have read and fully understand the above statements as they apply to me. I acknowledge that I understand treatment, payment, enrollment in any health plan, or eligibility for benefits are not conditioned on signing this authorization. I hereby authorize to the disclosure of the medical records to the purpose and extent stated above.

Medical Records Name: _____

Current Name: _____

Social Security Number: _____

Date of Birth: _____

Current Address: _____

Current City/State/Zip: _____

Home Phone: _____

E-mail Address: _____

Signature: _____

Witness: _____

Date: _____

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