

Authorization To Release Medical Records:

PATIENT INFORMATION:

Name (print) _____

DOB _____

SSN (last 4) _____

****After December 12, 2025 form MUST be mailed to****

Stephen A. Turner, MD OB/GYN

2411 Southway Drive

Columbus, Ohio 43221

INFORMATION WILL BE SENT TO THE PATIENT:

Patient Name _____

Home Address _____

City _____

State _____

Zip _____

Phone _____

Alt Phone _____

INFORMATION TO BE RELEASED: (CHECK ONE)

The most recent 5 years of pertinent information (chart notes, labs, x-rays and special tests)

All medical records

PATIENT AUTHORIZATION:

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted disease, drug and /or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

MY RIGHTS:

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy Laws.

Signature: _____

Date: _____

(Patient, guardian, or authorized representative)

Once your request is received, you will be informed of the exact fee prior to copying your records.

Records will be copied once medical records and postage fee is paid in full.

\$25.00 flat fee for 5 years of medical records

Fee for medical records 5 years and beyond will be assessed based upon the size of the chart.

This authorization will expire 90 days from date signed.