A Personal Choice
3613 Haworth Drive
Raleigh, NC 27609
(919) 977-5050 (Phone) (919) 883-4036 (Fax)
www.tubal-reversal.net

# Medical Records Release Form

Please check this completed form for accuracy before printing it. Then sign and date the printed form and initial the three authorization requirements at the bottom. You will then need to fax or mail the completed and signed form to the hospital's medical records department where you had your tubal ligation performed or to the doctor's office who performed the surgery.

**Medical Records Personnel:** Please include all three (3) pages of this Medical Records Release Form with the requested records. If you do not include the contact information we may not be able to contact the patient.

## AUTHORIZATION FOR RELEASE OF CONFIDENTIAL MEDICAL INFORMATION

I, _____ authorize_____
(Patient's name) (Name of hospital or doctor's office)

to release a copy of my OPERATIVE REPORT from my TUBAL LIGATION and a copy of my PATHOLOGY REPORT from my TUBAL LIGATION, ALONG WITH THIS RECORDS RELEASE REQUEST FORM to FAX#: (919) 883-4036 or by mail to:

Tubal Reversal A Personal Choice
3613 Haworth Drive
Raleigh, NC 27609

**REMINDER:** Please fax or mail my records with a copy of this Records Release Request Form.

Please include all three (3) pages of this Medical Records Release Form with the requested records. If you do not include all three pages, Dr. Monteith's staff may not be able to contact me.

The purpose of the requested disclosure is to allow Dr. Monteith to review my medical records in order to determine if tubal reparative surgery will be possible.

**Name at the Time of Surgery:**

**Date of Your Tubal Ligation:**

**Your Current Name:**

**Date of Birth:**

**Street Address:**

**Address:** (Line 2)

**City:**

**State / Province / Region:**

**Zip / Postal Code:**

**Home Phone:**

**Work Phone:**

**Cell Phone:**

**Email:**

_____ (initial) I understand that I have the right to withdraw my authorization at any time except to the extent that action has already been taken pursuant to this authorization. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department.

_____ (initial) I understand that authorizing the disclosure of this health information is voluntary, I can refuse to sign, and future treatment, payment, or eligibility for benefits will not be based on whether or not I provide authorization for the requested use or disclosure. I understand that the recipient may be prohibited from disclosing substance abuse information. I understand that I may inspect or copy the information to be disclosed (with a reasonable charge).

_____ (initial) I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient of the information and is no longer protected by federal confidentiality laws.

Unless otherwise revoked, this authorization will expire six months from the date of the signature listed below.

**Date:**

**Signature:**