

Women's Medical Care, P.C.

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Authorization for Release of Medical Records

I, _____
(Patient Name) (Any Previous Name)

Address: _____ City/State/Zip _____

Date of Birth: _____ SSN: _____ Phone: _____

Authorize: _____ Phone #: _____
_____ Fax #: _____

-to release my medical records including confidential and / or communicable disease- related information, including HIV or AIDS information, and to transmit my records by FAX

To: _____ Phone #: _____
_____ Fax #: _____

****PLEASE DO NOT SEND CD'S****

Type of records requested: _____ Operative Reports _____ X-ray Reports _____ Hospital Records
_____ Lab Results _____ Progress Notes
_____ Other _____

_____ Include all records

OR

_____ Include records from dates _____ to _____ only.

This authorization is valid for (Check one):

_____ This request only.

_____ One year from the date of this authorization OR until _____ (insert date.)

I understand that I may cancel this authorization at any time by submitting a written request to the address provided at the top of this form.

Patient Signature _____ Date _____

Witness, Women's Medical Care _____ Date _____

Delivered to Dr's box

Faxed

Mailed

Date _____

