

CONSENT FOR RELEASE OF MEDICAL RECORDS

Patient's Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Street Address \_\_\_\_\_

( ) \_\_\_\_\_

City, State, Zip Code \_\_\_\_\_

Telephone \_\_\_\_\_

I hereby consent and authorize

\_\_\_ ASSOCIATES IN WOMEN'S HEALTHCARE, PA

OBTAIN RECORDS FROM:

\_\_\_ OTHER

Provider \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_

Fax \_\_\_\_\_

To release copies of my medical records (protected health information), including current and previous medical records from other practices and practitioners, hospitals and/or clinics which are a part of my medical records. PLEASE NOTE: This authorization includes consent for the release of alcohol, drug, psychiatric and psychological information; and any information relating to pregnancy, sexually transmitted diseases, HIV testing, AIDS, and any AIDS-related syndromes. It also includes any information concerning cancer, cancer testing, and cancer results. I agree that a copy of this release or a fax of this release shall be valid as this original release. Please send copies of all requested information as soon as possible to the address/fax listed below:

- SEND ALL OF MY RECORDS
- SEND RECORDS FROM (DATE) \_\_\_\_\_ TO (DATE) \_\_\_\_\_
- SEND MY RECORDS PERTAINING TO: \_\_\_\_\_

Provider \_\_\_\_\_

MAIL RECORDS TO:

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

Zip Code \_\_\_\_\_

Telephone \_\_\_\_\_

PURPOSE FOR DISCLOSURE: \_\_\_ Referral to Specialist \_\_\_ Primary Care \_\_\_ Insurance

Transfer of Care to \_\_\_\_\_ Other (specify) \_\_\_\_\_

I understand that if the person or entity that receives this information is not a health plan or health care provider covered by federal privacy regulations, the released information may be re-disclosed by the recipient and may no longer be protected by federal or state law.

I understand that I may revoke this authorization at any time by notifying Associates in Women's Healthcare in writing. However, if I choose to do so, I understand that my revocation will not affect any actions taken by Associates in Women's Healthcare before receiving my revocation.

This authorization expires sixty days from the date of signature unless otherwise specified: \_\_\_\_\_

X  
Signature of patient (if guardian or personal representative of estate, please specify) \_\_\_\_\_ Date \_\_\_\_\_

FOR OFFICE USE:  
DATE RECEIVED \_\_\_\_\_ INITIALS \_\_\_\_\_ MD AUTHORIZATION \_\_\_\_\_ DATE \_\_\_\_\_  
DATE RELEASED \_\_\_\_\_ FAXED \_\_\_\_\_ MAILED \_\_\_\_\_ PICKED-UP \_\_\_\_\_ INITIALS \_\_\_\_\_