Women's Healthcare Affiliates, P.A.

MEDICAL RECORDS RELEASE/REQUEST PROTECTED HEALTH INFORMATION

Patient Name: _____ **Date of Birth:**_____
Address: _____ **Telephone:**_____
City:_____ **State/Zip:**_____

I HEREBY AUTHORIZE WOMEN'S HEALTHCARE AFFILIATES P.A. TO:

CHECK ONLY ONE BOX PER FORM

[ ] REQUEST MY MEDICAL RECORDS FROM **[ ] SEND MY MEDICAL RECORDS TO**

Name:	**Name:**
Address:	**Address:**
Phone: **Fax:**	**Phone:** **Fax:**
City: **State:** **Zip:**	**City:** **State:** **Zip:**

PURPOSE FOR THE *RELEASE* OF INFORMATION:

(***Use back side of paper if additional space is needed for reason)***

[ ] TO OBTAIN INSURANCE COVERAGE [ ] GOING TO SPECIALIST/ COORDINATION OF CARE [ ] MOVING
[ ] CHANGING PHYSICIAN_____
[ ] OTHER (***Be specific please***) _____

HEALTH INFORMATION TO BE DISCLOSED (SPECIFY THE EXACT INFORMATION INCLUDING DATES OF SERVICE):

[ ] Complete medical record (any & all)
[ ] Specify Dates of Service: _____ [ ] Records marked below

[ ] Office visits	[ ] Consultation Notes	[ ] Procedure Notes	[ ] Lab Results (including HIV & communicable diseases)
[ ] History & Physical	[ ] Operative Reports	[ ] Radiology Reports	[ ] Other (specify)_____
[ ] Pathology results	[ ] Billing Records	[ ] Nursing Notes	_____

_____ _____
Signature of Patient Signature of Patient's Representative

_____ _____
Date Representative Relationship to patient

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