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 Recor (any & all)

[ ] Specify Dates of Service _____ [ ] Records Marked Below

[ ] Office Visit	[ ] 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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