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 _____