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

R. David Reeves, M.D., F.A.C.O.G

Bryan K. Behne, M.D., F.A.C.O.G

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