Women's Health Partners, LLC

Diplomates of the American Board of Obstetrics & Gynecology
www.myobgynoffice.com

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CONSENT TO RELEASE & OBTAIN PATIENT RECORDS

I hereby authorize Women's Health Partners, LLC

_____ To RELEASE copies of my medical records to:

_____ To RECEIVE copies of my medical records from:

Name: _____

Address: _____

Phone: _____ Fax: _____

I understand that my records may contain information pertaining to my diagnosis or treatment of my medical, psychiatric, AIDS/ARC/HIV testing, alcohol or drug abuse condition. I also understand that any topic discussed during my medical treatment was documented, and therefore, will be released.

_____ Send all of my records

_____ Send only the following records: _____

_____

Patient Name: _____

SS #: _____ Date of Birth: _____

Patient Address: _____

_____

I understand the following:

a. I may revoke this authorization at any time by providing written notice to the practice.
b. I may not be able to revoke this authorization if the practice has already taken action utilizing this authorization or if the authorization was obtained as a condition of obtaining insurance coverage.
c. The practice will not condition treatment or payment based on my signing this authorization.
d. I am signing this authorization freely.
e. No one has pressured me to sign this authorization.
f. The information disclosed in this authorization may be subject to re-disclosure by the practice and no longer protected by federal law.
g. I acknowledge that I have had an opportunity to review this authorization and understand the intent and the use.

Signature: _____ Date: _____