Date: _____

NuWave Women's Health Medical Release Form

Patient Name: _____ Date of birth: _____

I, _____, hereby authorize and request **NuWave Women's Health** to release copies of my medical records to (Check off) _____ myself _____ doctor office

Dr._____, Phone: _____ Fax: _____

Office: _____, Location: _____

Reason For Request

_____Leaving/ Moving back to my Country, _____

_____ Moving/relocating out of the City/State, _____

_____ Transferring my care to another provider of service, Dr. _____

_____ Out of network/Insurance/Plan _____

_____ For a second opinion, _____

Other: _____

Forward/ Send My Records To

_____Via Fax from Dr. Office to Dr. Office, Fax # _____

_____ Will pick up medical records **note below for pick up details**

_____Via mail to the address _____

I understand that copies of my medical records will be ready for pick up or mailed within the next 7 to 10 business days and there's a charge for medical records of $1.00 per page for the first 25 pages, and $0.25 for every page thereafter. Payment must be made prior to submission.
Total Due $_____
Fee waived by management _____

I have read, understood and agree to the proceeding terms of this policy

Patient's Signature: _____ Date: _____

Records Released by: _____ Date: _____

NuWave
Women's Health