Women's Health Partners, LLC

Diplomates of the American Board of Obstetrics & Gynecology
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Acct #: _____

CONSENT TO RELEASE/ OBTAIN PATIENT RECORDS

I hereby authorize you to release confidential health information about me, by releasing a copy of my medical records, or summary or narrative of my protected health information, to the physician/person/facility/entity listed below. 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.

Patient Information (please print): **NOTE: WE DO NOT ACCEPT DISCS**

Name: _____ Date of Birth: _____

SS #: _____ Phone: _____

Address: _____

Please release the following records:

- ☐ Complete Records
- ☐ History & Physical
- ☐ Pre Natal Records **(no images please)**
- ☐ Lab Reports
- ☐ Radiology Reports
- ☐ Pathology Reports
- ☐ Operative Reports
- ☐ Hospital Records
- ☐ Other (please specify below)

From:

Name: _____

Phone: _____ Fax: _____

To:

Name: _____

Phone: _____ Fax: _____

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 redisclosure by the practice and no longer protected by federal law.
g. I acknowledge that I have had the opportunity to review this authorization and understand the intent and the use.

Signature: _____ **Date:** _____

PLEASE DO NOT FAX IMAGES

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