Women's Health Care Specialists

Medical Records Release Form from another provider

(To be used to provide us with your records from another provider)

Patient Name: _____ Soc. Sec. # _____

Address: _____ Date of Birth: _____

By signing this authorization, I authorize _____ to use and/or disclose certain protected health information (PHI) about me. I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed below.

Phone: _____ Fax: _____

Please send my protected health information to the following location:

Women's Health Care Specialists
9470 Annapolis Road, Suite 316
Lanham, MD 20706
Phone: 301-459-4317
Fax: 301-459-5784
e-mail: service@whcsmd.com

My authorization extends or is limited to:
___ Records of my visits from 2011 to present unless otherwise specified.
___ Patient history
___ Progress notes
___ Diagnostic reports
___ Consultation reports
___Other: must specify _____

This authorization is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as provided by law.
2. A photocopy or fax of this authorization is as valid as the original.
3. I may revoke this authorization at any time, except where information has already been released.
4. Treatment, payment and operation of our business may not be conditioned upon this authorization.
5. The release of information authorized may be subject to re-disclosure by the recipient.

_____ _____

Patient Signature [or parent, guardian or legal representative]: Date