CENTREVILLE OB/GYN
14701 LEE HWY, SUITE 304
CENTREVILLE, VA 20121
703-830-4388|703-830-4188 (f)

RESTON WOMEN'S CENTER
1850 TOWN CENTER PKWY,
SUITE 650, PAVILION II,
RESTON, VA 20190
703-955-5978| 571-267-7903(f)

AUTHORIZATION TO RELEASE HEALTHCARE INFORMAION

Patient's Full Name:__________________________________Date of Birth: ________________

Previous Name:_______________________________Social Security#: ____________________

I request and authorize ____

To release healthcare information to the following parties:

Name:_______________________ **Reston Women's Center**___________________________

Address:__________ **1850 Town Center Dr., Pavilion II, Suite 650, Reston, VA 20190**_________

Phone:_______ **(703) 955-5978**______________Fax:________ **(571) 267-7903**________________

This request pertains to the following information:

☐ All healthcare information

☐ Other: ____

☐ Yes ☐ No I authorize the release of STD results, HIV/AIDS testing, whether negative or positive, to the person listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above

Patient Signature:____Date Signed: ______________