Complete Healthcare for Women
Obstetrics ● Gynecology ● Richard Lorenzo, D.O.
1050 Gilmore Ave., Suite A, Richland, WA ● 509-392-6700

Medical Records Release Form

Name: _____

Date of Birth: _____

Address: _____

Telephone: _____

I give _____ authorization to
(Previous office)
disclose or release my medical records, including:

All Medical Records _____
Lab Results _____
Radiology Reports _____
Other Reports (specify) _____

Please **do not** include the following information, if initialed:

Mental Health Diagnosis/Treatment Information _____
Drug & Alcohol Abuse Diagnosis/Treatment Information _____
Sexually Transmitted Disease Diagnosis/Treatment Information _____

The above records are for services provided **FROM**: _____ **TO**: _____

Records are to be sent to:

Complete Healthcare for Women, PLLC
Richard Lorenzo, D.O.
1050 Gilmore Ave., Suite A
Richland, WA 99352

Phone: 509-392-6700
Fax: 509-392-6699

This authorization shall expire on _____ or one year from the date originally signed.

I understand that this authorization is voluntary and it gives the authorized persons permission to use them as stated.

Signature _____ Date _____

Printed Name _____