



## AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, the undersigned, hereby authorize

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To release the following information from my medical records: The authorization includes release of information concerning HIV testing or treatment of AIDS, AIDS related conditions, drug or alcohol abuse, and drug related conditions, and/or psychiatric/ psychological conditions. The following information may be released or reviewed:

Entire Medical Chart- including previously released records

Only the following items:

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**Please FAX above records to: 513-985-9391 ( We prefer records to be faxed)**

OR MAIL TO:

Associates in Women's Health  
10700 Montgomery Road  
Suite 311  
Cincinnati, Ohio 45242  
513-794-1500

I hereby state that I have read and fully understand the above statements as they apply to me. I hereby consent to the disclosure of the treatment records for the purpose and extent stated above. I release the above named institute of any claim pertaining to the release and use of medical data of the contents thereof.

Patient Name: \_\_\_\_\_ Birth Date \_\_\_/\_\_\_/\_\_\_\_\_  
(Please Print)

Street Address: \_\_\_\_\_

City, State and Zip: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_\_\_  
(Patient, parent or legal guardian)

Telephone: \_\_\_\_\_ Witness: \_\_\_\_\_