AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, the undersigned, hereby authorize **Associates in Women's Health**
10700 Montgomery Road
Suite 311
Cincinnati, Ohio 45242

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:

_____

_____

_____

Please forward above records to: _____

_____

_____

Phone: _____

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: _____

Please allow 30 days for records to be copied and sent.

Are you transferring your Care? Yes___ No ___

If yes, what is your reason for leaving?

- ☐ **I am moving**
- ☐ **I am unhappy with the staff**
- ☐ **I am unhappy with the care I'm receiving from my doctor**
- ☐ **I would prefer a single doctor practice.**
- ☐ **My Doctor is not in network**
- ☐ **Other:**_____