RESTON WOMEN'S CENTER

1850 TOWN CENTER DRIVE

PAVILION II, SUITE 650

RESTON, VA 20190

PHONE: (703) 955-5978

FAX: (571) 267-7903

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: _____