Woman to Woman Gynecology, PLLC
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Medical Records Release Form

Patient Name:_____ DOB:_____

Street Address:_____

City, State, Zip Code:_____ Phone:_____

I hereby authorize the release of information to Woman to Woman Gynecology from:

Name:_____

Address:_____

City, State, Zip Code:_____

Phone:_____ Fax:_____

For the purpose of:

☐ Continued Treatment ☐ Legal Review ☐ Insurance Purposes

☐ Other (please describe)_____

Records are for services dated:_____

1. I understand that this authorization will expire six months from this date. A photocopy of this form will be considered as valid as the original.
2. I understand that this health information may include HIV-related information, alcohol, drug, sexually transmitted diseases, information relating to pregnancies and/or information relating to cancer diagnosis.
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV/AIDS related information and psychiatric/mental health information. I understand that I may revoke this authorization at any time except to extent that the information has already been released pursuant to this authorization and before I have revoked my authorization.
4. My health care and payment for my health care will not be affected if I do not sign this form.

By signing below, I acknowledge that I have read and understand this authorization.

_____ OR_____

Signature of Patient Parent/Legal Guardian/Authorized Person

_____

Date

Date request faxed:
By: