Swor Women's Care
Sworcare.com

Gynecology • Obstetrics • Infertility • UroGynecology

G. Michael Swor, MD, FPMRS
Gynecology, Minimally Invasive/ Reconstructive Surgery
Kelly-Anne Shedd-Hartman, DO, FACOOG
Obstetrics and Gynecology
April Campbell, CNM
Allison Smith, ARNP
Cynthia Day, ARNP

PATIENT:

_____ _____
Name of Patient/ Previous Names | Date of Birth / Social Security Number

_____ _____
Street Address | City, State, Zip Code

AUTHORIZES:

_____
Name of Health Care Provider

_____
Street Address

_____
City, State, Zip Code

RELEASE OF PROTECTED HEALTH RECORDS TO:

_____
Name Of Health Care Provider/Plan/ Other

_____
Street Address

_____
City, State, Zip Code

INFORMATION TO BE RELEASED:

___ Full Medical Records as held by this office
___Medical Records for the period_____ through _____
___ Specific Information, as requested below:
_____
_____

PURPOSE FOR NEED OF DISCLOSURE:

___Further Medical Care ___Insurance/Eligibility
___Other(specify)_____

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

I understand I must be provided with a signed copy of this authorization. I understand written notification is necessary to cancel this authorization and I may obtain information on how to withdraw my authorization by contacting the office of the above noted healthcare provider. I understand that Swor Women's Care will not be able to release my records to someone else without a signed authorization. If I decided not to sign this form, Swor Women's Care will not refuse to continue treatment. By signing this authorization, I do expressly and voluntarily consent to the disclosure of the information checked above to the person/doctor/agency named above. I understand that if the person and/or organization listed above are not mandated by the federal privacy standards, the health information disclosed as a result of this authorization may be redisclosed without obtaining my authorization. I understand that I may be charged a fee for copying these medical records.

Signature Patient/ Legal Rep:_____ Date:_____