**Women's Healthcare Associates**

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# AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Name:_____ Date of Birth:_____
Last First Middle

I voluntarily authorize and direct the health care provider named below to disclose my health information during the term of this authorization to the recipient that I have identified below.

Name of Provider:_____
Address of Provider:_____ Fax _____

**Recipient and Address for Delivery of Records:**

_____
_____ Fax _____

I understand that the specific purpose of this authorization is to provide continuity of my care, for processing an insurance claim or to meet another specific desire of mine.

**Information to be disclosed:** This authorization permits the above named health care provider to disclose the following medical records:

☐ All of my health information that the provider has in his/her possession, including information relating to any medical history, mental or physical condition and any treatment received by me, including without limitation, x-rays, HIV/AIDS status, genetic testing, psychotherapy notes and other mental health information, drug, alcohol or other controlled substance information, billing information, correspondence, and records from my other health care providers that the above named health care provider may hold.

☐ All of my health information described above except for the following:

_____

☐ Only the following records or types of health information: (Insert dates of treatment, types of treatment or other designation.)

_____

**Term:** This authorization will remain in effect for one (1) year from the date this authorization is signed.

**Photocopy:** A photocopy, fax or electronic copy of this authorization shall be considered as valid as the original.

_____ _____
Signature Date

_____
Witness