



AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name: _____ **Chart ID #:** _____

SS #: _____ **DOB:** _____

Home Phone #: _____ **Work Phone #:** _____ **Cell Phone #:** _____

This authorizes Physicians For Women to provide a copy, summary, or narrative of my medical records as indicated by the checkmark(s) below, or otherwise release confidential information.

- Complete Record up to last 5 years including records from other practices
- Records of care from the following dates: _____ to _____
- Records concerning the following conditions: _____
- Other, please specify: _____
- Confer with person(s) listed below orally about my medical information:

- Transferring? YES NO

The reasons or purposes for this release of information are as follows: _____

HIV/AIDS (If applicable), I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records:
Initials: _____ **Date:** _____

Release the information to the following person(s):

Name: _____

Street: _____

City: _____ State: _____ Zip: _____

Expiration date: _____ or Expiration Event as detailed below:

- I understand that Physicians For Women will provide this information within 15 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to the rulings set forth by the Virginia Statutory Code.
- I understand that I may revoke this authorization in writing at any time by notifying Physicians For Women. Revoking this authorization will not affect uses or disclosures of my confidential information that occurred prior to revoking.
- I understand that refusal to sign this authorization will not in any way affect my treatment.
- I understand that confidential information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal or state law.
- I agree to be responsible for and pay the fee for providing copies of my medical information.

Patient Signature: _____ Date: _____

Charges: _____ payment type: _____ staff initials: _____