



**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: \_\_\_\_\_

Phone : \_\_\_\_\_ Fax : \_\_\_\_\_

- 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 a \$15.00 fee for providing copies of my medical information.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Charges: \_\_\_\_\_ payment type: \_\_\_\_\_ staff initials: \_\_\_\_\_