

MEDICAL RELEASE FORM

I undersigned and authorize you to release my Medical Records to Center For Women's Health & Wellness for acknowledged that this Medical Records may contain documentation of a nature to include HIV or Aids related conditions or psychiatric information.

PATIENT INFORMATION:

Full name: _____

Date of Birth: ____/____/____

Social Security: ____-____-____

Phone: ____-____-____

INFORMATION TO BE REQUESTED FROM

Name: _____

Address: _____

Phone: ____-____-____

Fax: ____-____-____

PURPOSE OF DISCLOSURE:

☐ Personal Use ☐ Legal Purpose ☐ Health Care ☐ Insurance
Purpose

☐ Other: _____

CHECK THE APPROPRIATE BOX(S) FOR TYPE OF INFORMATION TO BE RELEASED:

☐ Consult ☐ Discharge Summary ☐ Lab Report ☐ Verbal release info
☐ Historical/Physical ☐ EKG ☐ Progress Notes ☐ Outpatient Reports
☐ Radiology Reports ☐ Pathology Report ☐ HIV Results ☐ All Records
☐ Other: _____

I have been informed that there may be benefits or disadvantages to releasing this information. This authorization shall be valid for 90 days from the date of signature or from the date of completion of treatment whichever is later, unless otherwise expressly revoked by me in writing prior to that time. I understand that your policy requires payment of \$1.00 per p page copying fee Medical Records. If the records are mailed to a physician or another medical facility, there will be a copying fee charged. We required a minimum of 72 hrs. to process any requests.

Center For
**WOMEN'S HEALTH
& WELLNESS**

Patricia Ristic, M.D., F.A.C.O.G.
Susan Fox, D.O., F.A.C.O.O.G.
Darren Salinger, M.D., F.A.C.O.G.
Tiffany Leon, MSN, APRN, FNP-BC
Diana Zambrana, MSN, APRN, FNP-BC
Nelly Maurant Grass, MSN, APRN, FNP-BC

Patient Signature: _____

Legal Guardian Name: _____

Witness: _____

Legal Guardian Signature: _____

Date: ____/____/____

Relationship to Patient: _____