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Doctors for Women
A unique medical center for women's unique healthcare needs

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MEDICAL RECORDS RELEASE FORM

I herby authorize the use or disclosure of my health information as described below. I understand the information disclosed because of this authorization may be subject to re-disclosure by the recipient and will therefore no longer be protected by federal privacy regulations.

Patient Name: _____ **Date of Birth:** _____

Address: _____ **SSN:** _____

_____ **phone:**_____

Release Information to: _____

_____

_____

Phone **Fax**

Release Information from:_____

_____

_____

Phone **Fax**

Information to be released: ☐ All Records ☐ Progress Notes ☐ Labs Other: _____
Reason for request: ☐ Changing Physicians ☐ Self ☐ Specialist Consultation Other: _____

- I understand that if the person or entity receiving my health information is not a health plan or health care provider covered by federal privacy regulation, the health information may be re-disclosed by the recipient any may no longer be protected by federal or state law.
- I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan or eligibility for benefits.
- I understand that this authorization will expire 30 days after date listed below. I understand that I may cancel this authorization at any time by notifying the healthcare provider in writing. I understand that my cancellation will not affect any actions taken by the healthcare provider before receiving my cancellation.
- I understand that I may have a copy of this authorization.

_____ _____

Signature **Date**

∗ **There will be a processing charge for this request. The fees are as follows:**

1-25 pages $25.00
26-500 pages $.50 per page
Handling Charge $15.00

Make Check Payable to:
Doctors for Women

Date of Release: _____ Authorized by: _____

Copied / faxed / released by: _____