

Authorization of Release of Medical Records

This form must be completely filled out in order to process your records.

1. I (the undersigned) authorize: Women to Women Healthcare
8888 Ladue Road Suite 220

St. Louis, MO 63124

Ph#(314) 644-3336 Fax# (314) 644-5606

To release information from the records of _____
(Patient Last Name) (First Name) (MI)

Date of Birth _____ Soc Security # _____

2. Information is to be released to:

3. Purpose of Disclosure: _____
4. Information to be released, (a clear meaningful reason is required by law)

Date of Accident/Injury: _____ Injuries sustained _____
Check all that apply:

Record of Visits Progress Notes Consultation Reports Diagnostic Tests Billing Records
 X-ray Reports/Films Lab Results History & Physical Ekg's Operative Procedure Report
 Discharge Summary Other (must be specific) _____

Dates to be released: _____

5. I understand I may have a copy of this authorization and this consent may be revoked in writing at anytime. To initiate revocation of this authorization direct all correspondence to the person named above in section 3.

6. PLEASE INITIAL ANY OF THE FOLLOWING THAT APPLY:

No, I DO NOT authorize you to release information concerning mental health problems such as phobias, depression, anxiety, attention deficit disorders, etc.

No, I DO NOT authorize you to release any and all medical records in your possession related to a diagnosis or treatment of HIV or AIDS, or Sexually Transmitted Diseases or any ailment related thereto.

No, I DO NOT authorize you to release any information concerning alcohol and/ or drug abuse treatment.

7. This authorization is valid for a 90-day period from the date it is signed, if an expiration date is not provided.
Expiration Date _____

8. I understand my records may be copied by a service and there may be a fee charged that I will be Responsible for paying. A photocopy of this authorization is as valid as the original.

9. I understand that the information used of disclosed pursuant to the authorization may be subject to Re-disclosure by the recipient and may no longer be protected by Federal Law.

SIGNATURE: _____ DATE _____

Patient or personal legal representative (next of Kin or legal guardian to sign only if patient is a minor
If legally incompetent or deceased documentation must be attached showing legal representation)

PRINT NAME: _____

Relationship to Patient: _____