Authorization of Release of Medical Records

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

1) I _____ _____
(Name of Patient) (Date of Birth)

hereby authorize *Women To Women Health Care* ***to obtain records from***:

(Physican /Institution)	(Attention)
(Address)	(City/State/Zip)
(Phone Number)	(Fax Number)

2) ***Information is to be sent/released to***:

Women To Women Health Care 8888 Ladue Road Suite 220 St. Louis, MO 63124	*Dr. Cathleen Faris* *Dr. Michelle deVera* *Dr. Kathleen Hogan*
PH# 314-644-3336 FX# 314-644-5606	ATTN: MEDICAL RECORDS

3) Purpose of Disclosure:_____

4) ***INFORMATION TO BE RELEASED - PLEASE MARK ALL THAT APPLY***

__ALL RECORDS	__ OFFICE VISIT DR NOTES	__OPERATIVE REPORTS	__ULTRASOUND REPORTS
__BONE DENSITY TESTING	__PAP TESTING REPORTS	__PATHOLOGY/LAB REPORTS	__OTHER

DATES TO BE RELEASED: _____

5) I understand that 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 2.
6) I understand that my records may contain but are not limited to: history, diagnosis, and/or treatment of HIV(AIDs Virus), other Sexually Transmitted Diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. ***No, I do not consent to the release of this information.*** (initial) _____
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 that there may be a fee charged for copying my record that I will be responsible for paying. A photocopy of this authorization is valid as 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 of personal legal representative (next of Kin of 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 :_____