Virginia Women's Health Associates Gynecology

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RECORD RELEASE FORM

_____ _____/_____/_____
Print Patient Full Name Birth date

(_____)_____-_____
Best Contact Number

At the request of the individual, I _____, do hereby authorize.

Name of Company/Agency/Person: _____

Phone: _____ Fax: _____
To Release:
_____All Records
_____History & Physical _____Laboratory Reports Other_____
_____Progress Notes _____Radiology Reports
_____Operative Notes _____Pathology Reports

PLEASE RELEASE INFORMATION TO:

_____
Name of Company/Agency/Facility/Person

_____
Street Address City, State ZIP Code

_____
Phone Number/Fax Number

The purpose/reason for request is: _____

I can be reached at _____ if there are any questions regarding this request. I understand that there is a $30 handling fee. Once we have received payment, we will process your request. Please be advised that it takes up to 10 business days to process. Under the privacy rules, I have the right to revoke this authorization at any time. I also understand that by disclosing my medical records, Virginia Women's Health Associates cannot guarantee the recipient will not use or disclose records in violation of the Privacy Rules.

_____ _____
Signature of individual or guardian or Personal Representative of patient's estate **Date**