



Providence Women's Health Care
MEDICAL RECORDS RELEASE FORM

1) PATIENT INFORMATION:

Name	Address	City	State	Zip
Date of Birth	() Daytime Phone	Previous Name		

2) AUTHORIZES:

Providence Women's Healthcare
 Name of Medical Office

1300 Upper Hembree Road, Building 100, Suite D	Roswell	GA	30076	(770) 670-6170	(770) 670-6171
Address	City	State	Zip	Phone Number	Fax Number

3a) TO DISCLOSE TO:

Self, Delivery Options: Pick up Mail to address above

To be picked up: I hereby authorize _____ to pick up my records. (Photo ID required.)

Send to: _____
 Name of Health Care Provider / Plan / Other

Address _____ Or Health Care Provider FAX # _____

3b) TO OBTAIN FROM:

_____ Name of Health Care Provider / Plan / Other

Address _____ () Phone Number _____ () Fax Number _____

4) DATE(S) OF INFORMATION TO BE DISCLOSED/OBTAINED: From _____ to _____ **If left blank, only information from the past two (2) years will be disclosed/obtained.**
 (month/year) (month/year)

5) INFORMATION TO BE DISCLOSED/OBTAINED:

All medical records related to (specify condition, treatment, etc.): _____

Radiology films/images (specify test): _____

Specific records/information as follows: _____

I DO NOT WANT THE FOLLOWING INFORMATION DISCLOSED/OBTAINED (as defined by applicable state and federal laws):

Alcohol/Drug Abuse HIV Test Results Mental Health / Developmental Disabilities

6) EXPIRATION: This Authorization is good until the following date / event: _____
 Note: If this item is left blank, the authorization will expire in one (1) year from the date signed.

7) PURPOSE (Check all that apply - copy fees apply) Transfer of Care Insurance Eligibility/Benefits Personal (at my request)

Other: _____

8) YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION: I am aware that I have the right to inspect and receive a copy of the health information I have authorized to be used and/or disclosed by this Authorization. **I understand that I may be charged a fee for record copies.** In addition, I understand that I do not need to sign this Authorization in order to receive treatment. I also am aware that I may revoke this Authorization by notifying Providence Women's Healthcare in writing. However, I understand that my revocation will not be effective as to uses and/or disclosures: (1) already made in reliance upon this Authorization; or (2) needed for an insurer to contest a claim/policy as authorized by law if signing the Authorization was a condition to obtaining insurance coverage. I realize that the information used and/or disclosed pursuant to this Authorization may be subject to re-disclosure and no longer protected by federal privacy law.

9) SIGNATURE OF PATIENT / LEGAL REP: _____ **DATE:** _____

If signed by a person other than the patient, complete the following:

1. Individual is: a minor legally incompetent or incapacitated deceased

2. Legal authority: parent* legal guardian next of kin / executor of deceased activated POA for Health Care

* By signing above, I hereby declare that I have not been denied physical placement of this child.

For Office Use Only:

Signature/ID verified Yes No Completed by: _____ Date released _____ # of pages _____