THE WOMAN'S GROUP

Obstetrics, Gynecology, Infertility, & Menopause

EXCELLENCE IN WOMEN'S HEALTHCARE

AUTHORIZATION FOR REQUEST OF MEDICAL RECORD INFORMATION

PATIENT NAME: _____

ADDRESS: _____

DATE OF BIRTH: _____ **SOCIAL SECURITY # (last four digits only):** _____

I hereby request and authorize:

_____

Name of healthcare facility

_____

Address

_____

City State Zip

_____

Phone Fax

To release to:

_____

Name of person or facility requesting information

_____

Address

_____

City State Zip

_____

Phone Fax

The foregoing is subject to such limitations as indicated below:

( ) 1. Confined to records regarding admission and treatment for the following medical condition:

_____

( ) 2. Covering records for the period from _____ to _____

( ) 3. Confined to the following specific information: _____

( ) 4. NO LIMITATIONS PLACED ON DATES, HISTORY OR ILLNESS, OR DIAGNOSTIC AND THERAPEUTIC INFORMATION, INCLUDING ANY TREATMENT FOR ALCOHOL AND DRUG ABUSE AS PROTECTED BY FEDERAL REGULATION 42CFR, PART II, PSYCHIATRIC/PSYCHOLOGICAL INFORMATION AND AIDS RELATED INFORMATION, INCLUDING TESTING, FS 490.32 AND/OR 90.503, 381.609.

This authorization shall expire one hundred eighty (180) days from the date signed.

_____

Signature Date Relationship

_____

Witness Date

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