

ASSOCIATES IN WOMEN'S CARE, P.C.
AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Phone: (719) 591-6666 Fax: (719) 573-0731

This release expires 90 days from the date of signature or upon written notification.

Patient's Name: _____

Date of Birth: _____ Social Security Number: _____

Previous name under which records may be filed: _____

Patient's Address: _____

_____ Phone: _____

Doctor name: _____ Approximate last visit date: _____

I specifically authorize Associates in Women's Care, PC to release my Medical Records as described on this form to the recipient listed below. Will your records be a) mailed or b) picked up?

Please release my Medical Records to:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

We can only copy our records, we CAN NOT forward copies of your records that we have received from any other physician. You will need to obtain these records directly from the physician providing your care.

_____ All records generated in this office.

_____ Other: _____
(specific dates of treatment or specific parts of the record)

Please release all information except the following. If these are marked we WILL NOT release.

- | | |
|--|---|
| <input type="checkbox"/> Drug Abuse if Any | <input type="checkbox"/> Substance Abuse if Any |
| <input type="checkbox"/> Psychological or Psychiatric Conditions
If Any | <input type="checkbox"/> AIDS/HIV if Any |

Are you leaving the practice from which you are requesting records from? Yes _____ No _____

If yes, please explain: _____

Request for medical records may require up to 10 days to process. Our charge for copying medical records is \$5.00 for 1-5 pages and \$14.00 for 6-10 pages. Over 11 pages there will be a charge of \$.50 per page and over 40 pages there will be a charge of \$.33 per page. There is no charge for records sent directly to another physician.

Patient Signature: _____ Date: _____
(or legally authorized representative)

Relationship to Patient if legal representative: _____