CONSENT TO RELEASE / OBTAIN MEDICAL RECORDS

DATE ____________

Patient: FIRST ____________________________ LAST ___________________________________

Date of Birth ______________ Social Security Number _____________________________

I hereby authorize Advanced Women's Healthcare, P.A. **(CHECK ONE)**

________ To RELEASE copies of my medical records to: **________To RECEIVE copies of my medical records from:**

Name/Business____

Address____

Phone____ Fax____

I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-health care provider, the released information may no longer be protected by federal and state privacy regulations.
The following information is requested and may be released:

- ☐ **ALL RECORDS**
- ☐ **Pap Smear and Exam Notes (indicate date range) ___________________**
- ☐ **OB Records Only (indicate date range) ___________________**
- ☐ **Mammogram Films and Reports (indicate date range) __________________**
- ☐ **Lab Results Only (indicate date range)__________________**
- ☐ **Other ______________________________**

By checking ALL RECORDS, I hereby give my express consent to release all medical records regarding my treatment, including genetic information and testing, family history, psychological treatment, drug abuse, alcohol use, human immunodeficiency virus (HIV) infection including acquired immunodeficiency syndrome (AIDS) or test for HIV, or sexually transmitted diseases.
***PLEASE SPECIFY description of purpose of the use and/or disclosure:**

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I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. I further understand that I may revoke this authorization at any time by notifying Advanced Women's Healthcare, P.A. in writing. I also understand that the written revocation must be signed and dated with a date that is later than the date on this Authorization. The revocation will not affect any actions taken before receipt of the written revocation. I understand that copies of records are subject to a $25.00 minimum fee.

____ **_____/_____/________**
(Signature of Patient or Representative) **Date**

(_______) ____________-_____________
(Daytime Phone Number)

OFFICE USE ONLY:
date records sent: ___________ staff initials _______

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