Medical Records Release Form from uS

(To be used for sending your records from us to another provider/entity)

Patient Name: _____ Soc. Sec. # _____

Address: _____ Date of Birth: _____

By signing this form, I authorize Women's Health Care Specialists to (check one):
☐ Release my confidential medical record to the entity listed below.

Name: _____

Street: _____

City: State: Zip: _____

Phone # _____ Fax # _____

The information will be used or disclosed for the following purposes:

My authorization extends or is limited to:
___ All records of my visits from _____to _____
___ Progress notes from date of service _____
___ Diagnostic reports from date of service _____
___ Consultation reports from date of service _____
___ All of the above
___ Other: must specify _____

This authorization is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as provided by law.
2. A photocopy or fax of this authorization is as valid as the original.
3. I may revoke this authorization at any time, except where information has already been released.
4. Treatment, payment, and operation of our business may not be conditioned upon this authorization.
5. The release of information authorized may be subjected to re-disclosure by the recipient.

This authorization will expire in 30 days.

_____ _____

Patient Signature [or parent, guardian or legal representative]: Date

Women's Health Care Specialists

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