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Patient Information

Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Release Information

Release Records from CWH to:

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____
Fax: _____

Release Records to CWH from:

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____
Fax: _____

Specify records: Please check all that that is applicable to be released

Medical records shall include all confidential AIDS/HIV, alcohol, drug and mental health related information, unless specified otherwise.

- ALL RECORDS, Operative Reports, Ultrasounds, Lab/Pathology Reports, Pre/Post-Natal Records, Mammograms, Pap Smears, Progress Notes, Other:

Please check reason for request:

- Moving, Transferring Care, Patient's Request, Continuation of Care, Other:

This authorization shall become effective immediately and shall remain in effect for one year from date of signature unless a different date is specified here
Personal requests for duplicate copies of records will be subject to a \$35 fee, it's suggested that you make an additional copy of all your records before giving them to other providers outside of Comprehensive Women's Healthcare.

I have had the chance to read and think about the content of this authorization form and I agree with all statements made in this authorization. I understand that by signing this form, I am confirming my authorization for use and/or disclosure of the protected health information described in this form with people/and or organizations named in this form.

Signature: _____ Date: _____

Personal Representative Signature: _____ Relationship: _____

PLEASE NOTE COPYING OF RECORDS CAN TAKE UP TO 7 BUSINESS DAYS TO BE PROCESSED

Office Use Only
Date Received: _____ Date Released: _____ Provider Initials: _____ Sent By: _____

PLEASE DO NOT FAX RECORDS IF MORE THAN 10 PAGES