



advanced women's health specialists

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name: _____ Date of Birth: _____

Phone Number: _____

<p>*CHECK ONE</p> <p>___ Please OBTAIN Information FROM:</p> <p>___ Please SEND Information TO:</p> <p>_____</p> <p>Name of physician, hospital, or other</p> <p>_____</p> <p>Street Address</p> <p>_____</p> <p>City/State/Zip</p> <p>_____</p> <p>Phone _____ Fax _____</p> <p>Records pertaining to: _____</p> <p>_____</p>	<p>*These records released for purpose of:</p> <p>___ Change Provider (Please give contact Info. Below)</p> <p>___ Insurance: _____</p> <p>___ Legal</p> <p>___ Personal</p> <p>___ Referral to Specialist: _____</p> <p>___ Continuation of Care</p> <p>___ Other: _____</p>
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***Patients must initial for the following (If applicable):**

- ___ Psychiatric records/behavioral health/mental health records
- ___ AIDS (Acquired Immunodeficiency Syndrome) /HIV (Human Immunodeficiency Syndrome) records
- ___ Drug and/or alcohol/substance abuse records

Patients Signature: _____ Date: _____

Parent/Guardian (If a minor): _____ Date: _____

You may be charged for medical records:

\$1.34/page first 20 pages (\$26.80)
\$0.67/page 21-50

\$0.27/page ≥ 51

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