Health and Therapy for Women

Medical Record Request

By signing this form, you are giving consent for the provider to provide copies for protected medical and mental health information and records.

I authorize providers at Health and Therapy for Women to release health information, including information relating to any medical history, mental or physical condition and any treatment received.

Please indicate which of the following records are being requested:

Record dates from start to end for request:
Start: _____ **End**:_____

____Progress notes _____Lab records/results _____Referrals
____Billing statements _____Testing results

Client Name:_____DOB:_____
Address :_____

_____
Social Security Number:_____

Request form completed by:
Name:_____
Address :_____

_____
Social Security Number:_____
Signature:_____

Relationship to client _____Date_____

Release medical records to the following:

_____Self Name:_____

Address: _____

_____

Method records are to be sent (additional delivery fees may apply depending on method selected)

Postal _____ Fax_____ Pick-up _____