

Winchester Women's Health Care, P.C.
300 Trade Center, Suite 4750
Woburn, MA 01801
Phone: (781) 933-9993
Fax: (781) 933-5711

MaryAnn L. Millar, M.D.

Date _____

I, _____, am requesting a copy of my medical records be sent to:

Name: _____ Address: _____

Phone: _____ *Fax: _____

Patient Information: Date of Birth: ____/____/____ Year Last Seen in Office: _____

Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

Authorization for release of sensitive or statutorily protected information from the medical record.

The following categories of information will **NOT** be released from your records unless you indicate your authorization by **signing** next to the corresponding categories:

STD Testing _____

Sexual abuse _____

HIV testing _____

Sexual assault _____

Alcohol abuse _____

Other: _____

Substance abuse _____

Reason for release of medical records: _____

ALL medical records may be copied and sent: YES _____ NO _____

Exceptions _____

Please release ONLY _____

Records copied and sent: Date _____ Employee's Initials _____

Number of Pages _____ (\$0.25 each)

Time Spent _____ (\$20.00/hour)

TOTAL CHARGE _____

Medical records cannot be produced upon demand. Normal processing is 7 business days. We cannot release records that you have had transferred to us from another physician or facility.

Patient Signature _____

Signature of Parent of Guardian if necessary _____

Doctor Signature _____