Winchester Women's Health Care, P.C.
27 Main Street, UL-1
Andover, MA 01810
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_____
HIV testing_____
Alcohol abuse_____
Substance abuse_____
Sexual abuse_____
Sexual assault_____
Other:_____

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_____