advanced women's health specialists

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name: _____ Date of Birth: _____

Phone Number: _____

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

***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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