600 New Waverly Pl. Ste 310
Cary, NC 27518
Phone (919) 678 – 6900
Fax (919) 678-6901

Medical Records Release / Request

Please complete all of the information below.
I hereby request and consent to the release and disclosure of my personal health information to the below name physician or other named organization.

Patient Name: _____ **DOB**: ____/____/_____

Persons/Organization providing the information:	Persons/Organization receiving the information:
Name: Triangle Physicians for Women	Name: _____
Address: 600 New Waverly Place Ste 310	Address: _____
Cary, NC 27518	_____
Phone: (919) 678-6900	Phone: ( ) _____
Fax: (919) 678-6901	Fax: ( ) _____

I authorize the following information sent to the address above:

___ Copies of All Medical Records for the period of ___/___/___ to ___/___/___
___ Physical Exam Date: ___/___/___
___ Lab, X-ray, Test Results Date: ___/___/___
___ Records from Other Physicians Name of Physician: _____
___ Immunization Record
___ Other _____

Reason for Records Request:

_____

_____

I understand that the information outlined in this release will be disclosed according to the instructions of this release within (7) business days of Triangle Physicians for Women having received this release authorization. I understand that I am free to revoke this release authorization at any time by notifying the practice in writing. I also understand that the information disclosed under this release is subject to re-disclosure and no longer protected by the Privacy Regulations.
****Triangle Physicians for Women reserves the right not to fax records at any time, for any reason.****

**___ I am aware of the $10 fee to obtain a personal copy of my medical records. This fee is payable at time of request. ****There is NO fee for records going from provider to provider; this is considered a courtesy service.

Patient Signature: _____ **Date**: _____ / _____ / _____