Women First

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Authorization to Release Medical Records

_____ _____ _____

Print Patient Name **Date of Birth** **Request Date**

I hereby authorize Women First to release my protected health information in the manner listed below. I understand I may revoke this authorization at any time. I understand that refusal to sign this authorization will not in any way affect my treatment. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.**

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV) and/or other communicable diseases. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

Please release medical records pertaining to:

- ☐ **Complete records**
- ☐ **Specific items only (please list):**_____

Please release records FROM: _____
_____
_____

Please send records TO: _____
_____
_____

I agree to pay the federal electronic fee minimum of $6.50 for my chart to be sent to my new provider in electronic form

Or I agree to pay for a paper copy of my records per Code of Virginia § 32.1- 127.1:03. When the records or papers requested pursuant to subsection B1 are produced in paper or hard copy format from records maintained in (i) paper or other hard copy format or (ii) electronic storage, a health care provider may charge the requester a reasonable fee not to exceed $0.50 per page for up to 50 pages and $0.25 per page thereafter for such copies, $1 per page for hard copies from microfilm or other micrographic process, and a fee for search and handling not to exceed $20, plus all postage and shipping costs.

I, _____, am authorizing these medical records to be released.
Patient signature