

WOMEN'S HEALTH AND SURGERY CENTER
YOUR HEALTH • YOUR BABY • YOUR LIFE

2761 Jefferson Davis Highway St. 101
Stafford, VA 22554
Phone: (540)720-7340
Fax: (540)720-7341

2549 Cowan Boulevard
Fredericksburg, VA 22401
Phone: (540) 368-9472
Fax: (540) 656-2254

MEDICAL RECORDS RELEASE AUTHORIZATION

Patient: _____ DOB: _____ Phone: _____

PLEASE **OBTAIN** INFORMATION **FROM**:

PLEASE **RELEASE** INFORMATION **TO**:

Name of Provider/Clinic/Organization

Name of Provider/Clinic/Organization

Street Address

Street Address

City, State, Zip Code

City, State, Zip Code

Phone Number

Phone Number

Fax Number

Fax Number

I authorize the following information to be disclosed (Please indicate all that apply)

- | | | |
|--|--|--------------------------------------|
| <input type="checkbox"/> Complete Record | <input type="checkbox"/> Ultrasound/Sonogram Results | <input type="checkbox"/> STD Testing |
| <input type="checkbox"/> Labs Results | <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Other |

REASON for disclosure of health information: (Please indicate all that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> Transferring to a new physician | <input type="checkbox"/> Personal Use | <input type="checkbox"/> Dissatisfied (Please document reason) |
| <input type="checkbox"/> Moving | <input type="checkbox"/> Insurance | <input type="checkbox"/> Job/School |
| <input type="checkbox"/> Continuing Care | <input type="checkbox"/> Legal/Attorney | <input type="checkbox"/> Other |

ADDITIONAL HIPPA INFORMATION:

I understand that my original records will not be released, only copies.

I acknowledge that VA law allows for reasonable copy fees: \$10.00 Administration fee, \$0.50 per page for the first 50 pages and \$0.25 a page thereafter.

I understand that my refusal to sign this authorization will not affect my ability to receive treatment.

I understand that once my health care information is disclosed as I have authorized, it could be re-disclosed by the recipient and is no longer protected.

I understand that I have the right to withdraw this authorization by submitting a written request, except where actions have already been taken on the basis of this release.

SIGNATURE OF PATIENT

DATE