WOMEN4WOMEN
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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

TO REQUEST RELEASE OF MEDICAL INFORMATION PLEASE COMPLETE AND SIGN THIS FORM

I, _____hereby voluntarily authorize the disclosure of information from my health record.
(Name of Patient)

Patient Information:

Patient Name: _____Record Number: _____

Address: _____ Date of Birth: _____

Information Requested:

_____

_____

Purpose of Release:

_____

_____

Information Is Requested FROM:

Name of Person/Organization/Facility_____

Address: _____

Phone: _____ Fax: _____

Information Is To Be Released TO:

Name of Person/Organization/Facility: _____

Address: _____

Phone: _____ Fax: _____

_____ _____
Patient's Signature or Patient's Representative Date

_____ _____
Printed Name of Patient's Representative Relationship of Patient

This information is to be released for the purpose stated above and may not be used by recipient for any other purpose.

HIPAA Authorization For Release of Medical Records

Make a copy for your records