PHYSICIANS FOR WOMEN OF GREENSBORO

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Telephone# 336-273-3661 / Fax# 336-273-9438

____ ______________________

Print Patient's full name Date of birth

____ ______________________

Street address Social Security number

____ ______________________

City, State, Zip code Home telephone number

I do hereby authorize ____ to release:
Name of facility

_____ Entire Record _____ Specific date(s) of service_____________________________________
_____ Office notes _____ Pap Smear _____ Ultrasound _____ Mammogram
_____ Bone Density _____ Pathology _____ Lab reports: specify if needed_______________
_____ Hospital records _____ Other:____

_____I do _____ I do not authorize release of information related to AIDS (acquired immunodeficiency syndrome) or HIV (human immunodeficiency virus) infection, sexually transmitted disease(s), psychiatric care and/or psychological assessment and/or treatment for alcohol and/or drug abuse.

INFORMATION RELEASED TO:____
Name of Facility / Agency / Person

____
Address

____
Phone Number Fax Number

PURPOSE OF DISCLOSURE:
_____ Referral to specialist _____ Insurance _____ Worker's Comp _____ Change doctor
_____ Legal issue _____ Disability _____ Personal _____PCP / Internist
_____ Other:____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to the cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or facility receiving it and would then no longer be protected by this release. I understand the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

____ _________________________

Signature of Patient or authorized representative Date

Please provide the best telephone number to contact you in the event of a question:__________________

There will be a charge for personal copies or permanent transfer of your records due at time of service.