Associates in Women's Health Medical Records Release/Request Form

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(check one)

_____ **Releasing** information from us to you or your provider

_____ **Requesting** information from another provider to us

Date: ________________ Patient's Name: ____

DOB: ____________________________ Social Security Number: __________ - ______ - __________

I authorize Associates in Women's Health to (circle one) release / request the following:

_____ All Medical Records

_____ Other – Please specify: ____

Purpose of Request: ____

To / From:

Name: ____

Address: ____

____

Phone: (_______) _______ - _______ Fax: (_______) _______ - _______

I do not have to sign this authorization in order to receive treatment from Associates in Women's Health. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPPA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Office Manager at: 4700 Battlefield Pkwy. Suite 220 Ringgold, GA 30736.

Patient Signature: ____ Date: _________________________

Witnessed by: ____ Date: _________________________

4700 Battlefield Parkway, Suite 220 • Ringgold, GA 30736
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