Chester Women's Health
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

______________________________ ______________________

(Print patients full name) Birth date (Mo/Day/Yr)

______________________________ ______________________

(Street address) social security number

______________________________ ______________________

(City, state, zip code) Phone (Home)

At the request of the individual, I ______________________ (print patient first name), do hereby authorize ______________________ (doctor/facility name)

Address: ____

Phone: ______________ Fax: ______________

to release: (check all that apply)

____PROGRESS NOTES	____PATHOLOGY REPORTS	____ALL RECORDS
____OTHER DOCTORS NOTES	____LABORATORY REPORTS	____OTHER______________
____OBG/GN NOTES	____RADIOLOGY REPORTS	
____HOSPITAL NOTES	____ECG/EEG/CARDIC CATH	______________________

____ I do ____ I do NOT authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

INFORMATION RELEASE TO: **Linda Brown/ Chester Women's Health**
NAME (Physician, hospital, agency, etc)

12801 Ironbridge Road, Suite 100
Street address

Chester VA 23831 **ph:(804)706-5827**
City, state, zip **fax: (804)706-5819**

PLEASE MAIL RECORDS LARGER THAN 10 PAGES

PURPOSE OF DISCLOSURE:

____REFERRAL TO SPECIALIST	____INSURANCE	____WORKERS COMP
____LEGAL INVESTIGATION	____DISABILITY DETERMINATION	____PERSONAL

OTHER (SPECIFY)____

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 effect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized is furnished may not condition its treatment of me on whether or not I sign the authorization.

______________________________________ ______________

Signature of individual or guardian or Personal Representative of patient's estate **Date**

Reason for transferring: ______________________________________

Please provide current telephone number in the event we need to contact you: ______________________