

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 _____, do hereby authorize _____
(print patient first name) (doctor/facility name)

Address: _____

Phone: _____ Fax: _____

to release: (check all that apply)

<input type="checkbox"/> PROGRESS NOTES	<input type="checkbox"/> PATHOLOGY REPORTS	<input type="checkbox"/> ALL RECORDS
<input type="checkbox"/> OTHER DOCTORS NOTES	<input type="checkbox"/> LABORATORY REPORTS	<input type="checkbox"/> OTHER _____
<input type="checkbox"/> OBG/GN NOTES	<input type="checkbox"/> RADIOLOGY REPORTS	
<input type="checkbox"/> HOSPITAL NOTES	<input type="checkbox"/> ECG/EEG/CARDIAC 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: 12220 Iron Bridge Road, Suite A
Chester, VA 23831

Please circle provider: Phone: 804-706-5827 Fax: 804-706-5819

Linda Brown, M.D., FACOG

Ealena Callender, M.D.

Bryan Maxwell, DO, FACOG

Bethanie Kelley, WHNP

PLEASE MAIL RECORDS LARGER THAN 10 PAGES

PURPOSE OF DISCLOSURE:

<input type="checkbox"/> REFERRAL TO SPECIALIST	<input type="checkbox"/> INSURANCE	<input type="checkbox"/> WORKERS COMP
<input type="checkbox"/> LEGAL INVESTIGATION	<input type="checkbox"/> DISABILITY DETERMINATION	<input type="checkbox"/> 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: _____