

**WOMEN'S HEALTH ALLIANCE pka CAPITAL AREA OB/GYN  
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

\_\_\_\_\_  
Print Patient's Full Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
Daytime Phone Number

**RELEASE RECORDS FROM:** Women's Health Alliance, PA pka Capital Area OB/GYN Assoc.  
1505 SW Cary Parkway, Suite 300                      4414 Lake Boone Trail, Suite 308  
Cary, NC 27511    Raleigh, NC 27607  
Phone: (919) 467-2249 Fax: (919) 861-0495      Phone: (919) 781-7450 Fax: (919) 861-0495

**SEND RECORDS TO:**

\_\_\_\_\_  
Name of Company/Agency/Facility/ Person

\_\_\_\_\_  
Street Address including Suite #

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Fax Number

**SEND RECORDS TO:**

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**RELEASE INFORMATION PERTAINING TO:**

\_\_\_\_ Pregnancy    \_\_\_\_ Gynecological Visits    \_\_\_\_ Operative Notes    \_\_\_\_ Discharge Summary  
\_\_\_\_ Progress Notes    \_\_\_\_ Pathology Reports    \_\_\_\_ Laboratory Reports    \_\_\_\_ Emergency Reports  
\_\_\_\_ Radiology Reports    \_\_\_\_ ECG/EEG/Cardiac Cath    \_\_\_\_ Other \_\_\_\_\_

**PLEASE CHECK ONE**

**RELEASE ALL INFORMATION:** \_\_\_\_\_ Release information from \_\_\_\_\_ to \_\_\_\_\_  
\_\_\_\_ I DO    \_\_\_\_ I do NOT    authorize release of information related to AIDS or HIV infection,  
Psychiatric care and/or psychological assessment, and treatment for  
alcohol and/or drug abuse.

**PURPOSE OF DISCLOSURE:**    \_\_\_\_ Insurance    \_\_\_\_ Legal Investigation    \_\_\_\_ Workers Comp  
\_\_\_\_ Disability Determination    \_\_\_\_ Personal    \_\_\_\_ Change of Doctor    \_\_\_\_ Continuing Care

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 unless otherwise noted. I understand that I may cancel this request with written notification but that it will not affect 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 or furnished may not condition its treatment of me on whether or not I sign the authorization.

\_\_\_\_\_  
SIGNATURE of individual, guardian or  
Personal representative of patient's estate

\_\_\_\_\_  
DATE

**PLEASE NOTE: THERE IS A CHARGE FOR MEDICAL RECORDS. HEALTHPORT IS THE CONTRACTOR TO PROVIDE THIS SERVICE AND WILL INVOICE YOU DIRECTLY.**