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: ____

Name of Company/Agency/Facility/ Person

____

Street Address including Suite #

____

City, State, Zip Code

______________________ ______________________

Telephone Number **Fax Number**

SEND RECORDS TO: **Women's Health Alliance, PA pka Capital Area OB/GYN**

1505 SW Cary Parkway, Suite 300	4414 Lake Boone Trail, Suite 300
Cary, NC 27511	Raleigh, NC 27607
Phone #: (919) 467-2249 Fax #: (919) 861-0495	Phone #: (919) 781-7450 Fax #: (919) 861-0495

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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.