Women's Wellness Center

1705 E. Broadway Suites 300 & 340 Columbia, MO 65201
Ph 573-449-9355 fax 573-441-9355
www.womenswellnessnow.com

Consent to Release Medical Information

I hereby request that the following medical information be transferred

From:	**To:**
Women's Wellness Center	_____
1705 E. Broadway, Suite 300	_____
Columbia, MO 65201-5852	_____
Fax 573-441-9355	Fax _____
Phone 573-449-9355	Phone _____

Patient Name (list all names used in past) _____

Patient Birth Date _____ Social Security No. _____

Patient Address _____

Patient Phone Number(s) _____

I authorize the above doctor/practice to release information contained in my patient records, including, as applicable: Information about communicable diseases and infections which may include sexually transmitted diseases, psychiatric notes, alcohol abuse, drug abuse, HIV test results, and AIDS or AIDS related disease diagnosis, unless otherwise specified here _____

Information Requested: Dates of Treatment to be Released **FROM** _____ **TO** _____

- ☐ From All Providers
- ☐ From Specific Provider(s): _____
- ☐ WWC Records Only
- ☐ Hospital Records
- ☐ Prenatal Records
- ☐ Pap Results
- ☐ Operative/Pathology Reports
- ☐ Clinic Notes
- ☐ Labs
- ☐ Mammogram Results
- ☐ All Records
- ☐ Records related to the specific problem of _____

_____

_____

Our Patient Privacy Policy is available on our website at www.womenswellnessnow.com or you may request a copy be mailed to you.

I understand that this authorization shall be valid for one year, unless otherwise specified or revoked by me through written notice, and that such revocation would not be effective to the extent that the practice has relied on this authorization for its actions.

_____ _____

Signature of Patient Date