

Women's Wellness Center

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

Consent to Release Medical Information

I hereby request that the following medical information be transferred

From:

Fax _____

Phone _____

To:

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

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** _____

- | | | |
|---------------------------------------------------------------------------|-----------------------------------------------|------------------------------------------------------|
| <input type="checkbox"/> All Records | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Prenatal Records |
| <input type="checkbox"/> Labs | <input type="checkbox"/> History and Physical | <input type="checkbox"/> Operative/Pathology Reports |
| <input type="checkbox"/> Pap Results | <input type="checkbox"/> Mammogram Results | <input type="checkbox"/> Clinic Notes |
| <input type="checkbox"/> 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