



VIRGINIA  
WOMEN'S CENTER

**Medical Records Release - Patient Authorization for  
Access, Use, or Disclosure of Protected Health Information**

**\*\*Provide the patient with a copy of the signed form\*\***

**PLEASE COMPLETE ALL INFORMATION**

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_

Date of birth: \_\_\_\_\_ SSN: \_\_\_\_\_ Date of Request: \_\_\_\_\_

I would like the following access, use, or disclosure:

- Inspect:  
The department manager will contact you to schedule a convenient date and time to inspect your record.
- Copy:  
Please allow seven to ten business days to process. A fee will apply.  
\_\_\_\_ Please check here if you prefer to pick your records up. Otherwise, they will be mailed to the address above.
- Disclosure (copy sent to an individual or entity at your request):  
Please allow seven to ten business days to process.  
I request and authorize Virginia Women's Center to release health care information of the patient named above to:

Name: \_\_\_\_\_  
(Name of individual or entity to receive the information)

Address: \_\_\_\_\_

City, State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Office Telephone #: \_\_\_\_\_ Office Fax #: \_\_\_\_\_

Other:  
Please describe \_\_\_\_\_

Dates Requested: \_\_\_\_\_  Entire Chart

This protected health information is being used or disclosed for the following purposes:

At the request of the individual  Other – please describe \_\_\_\_\_

This Authorization expires on: \_\_\_\_\_ or the sooner of 6 months or when the following event occurs:

