



RELEASE OF MEDICAL INFORMATION

PATIENT NAME: _____ DOB: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
PHONE: _____ ALTERNATE PHONE: _____

PROVIDER RELEASING/AUTHORIZED TO DISCLOSE INFORMATION:

NAME: Women's Healthcare, P.C.
1260 Third Avenue SE
ADDRESS: Cedar Rapids, IA 52403
CITY: 319-362-1320 STATE: _____ ZIP: _____

PROVIDER RECEIVING INFORMATION :

NAME: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____

INFORMATION BEING REQUESTED:

<input type="checkbox"/> COMPLETE HEALTH RECORD	<input type="checkbox"/> HISTORY AND PHYSICAL EXAM
<input type="checkbox"/> CONSULTATION REPORT	<input type="checkbox"/> X-RAY REPORTS AND FILMS
<input type="checkbox"/> MEDICATION LISTS	<input type="checkbox"/> LABORATORY REPORTS
<input type="checkbox"/> DISCHARGE SUMMARY	<input type="checkbox"/> PROGRESS NOTE
<input type="checkbox"/> PHOTO, VIDEO, AND OTHER IMAGES	<input type="checkbox"/> PREGNANCY RECORDS
<input type="checkbox"/> IMMUNIZATION/SHOT RECORDS	<input type="checkbox"/> OTHER (PLEASE SPECIFY) _____

****SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW****
Y / N ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS) OR HUMAN IMMUNODEFICIENCY VIRUS (HIV)
Y / N ALCOHOL AND DRUG ABUSE TREATMENT
Y / N BEHAVIOR OR MENTAL HEALTH SERVICES

THIS INFORMATION IS BEING USED FOR:

<input type="checkbox"/> CONTINUED MEDICAL CARE	<input type="checkbox"/> PHYSICIAN MOVED
<input type="checkbox"/> DISSATISFIED WITH SERVICE PROVIDED	<input type="checkbox"/> INSURANCE CHANGE
<input type="checkbox"/> REFERRAL	<input type="checkbox"/> OTHER (PLEASE SPECIFY) _____

I UNDERSTAND THAT I MAY CANCEL OR REVOKE THIS AUTHORIZATION AT ANY TIME BY SENDING A WRITTEN NOTICE TO WOMEN'S HEALTHCARE, PC AND THAT MY CANCELLATION WILL TAKE EFFECT WHEN THE WRITTEN NOTICE IS RECEIVED AND WILL NOT APPLY TO ANY INFORMATION ALREADY RELEASED IN RESPONSE TO THIS AUTHORIZATION. THIS AUTHORIZATION WILL AUTOMATICALLY EXPIRE ONE YEAR FROM THE DATE SIGNED UNLESS SPECIFIED.

SIGNATURE: _____ DATE: _____

PRINTED NAME: _____ WITNESS: _____