Women's
HEALTH CARE
ASSOCIATES, P.A.
Obstetrics & Gynecology

Records Release Authorization

Patient (Please Print): ______________________________(former name)______________

My date of birth: ________________

Please release my medical records **from**: ____

____

as described below, and forward them **to**:

____

____

( ) All of my medical records in your possession, **excluding** records from other physicians.

( ) All of my records concerning treatment you have provided for the specific condition(s) as follows:

____

( ) All records concerning treatment provided between the following dates __________ and _________.

My records will be needed in time for my appointment on________________________________

My current address: ____

Former address: ____

Home phone: ________________ Work phone: ______________________________

Thank you for your attention to this matter.

Signature: __________________________________ Date: ______________________

Office: Request reviewed __________ Release approved ____________
Release date __________ By _____________________

med rec release updated 7/12/2007

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