431 Park Avenue
Suite 300
Falls Church, VA 22046
Phone: 703-528-6300
Fax: 833-438-5538

Healthcare For Women
OBSTETRICS and GYNECOLOGY

1875 Campus Commons Dr.
Suite 110
Reston, VA 20191
Phone: 703-437-8080
Fax: 833-438-5539

AUTHORIZATION TO RELEASE MEDICAL RECORD

Patient Name: _____ Date of Birth: _____
Address: _____ Phone: _____
City, State, Zip: _____ Account Number: _____

I hereby request and authorize for Healthcare For Women P.C. to release my records indicated:
Information to be released:

_____ Complete Medical Records
_____ Disability Forms / FMLA / Return To Work Forms

_____ Lab Results/Pathology Results From Following Dates: _____
_____ Office Notes Dates: _____
_____Radiology Reports Dates: _____

I SPECIFICALLY AUTHORIZE THE RELEASE OF THE FOLLOWING INFORMATION:

_____ Mental Health\HIV Related Information (AIDS related tests)
_____ Substance Abuse (including alcohol/drugs)

Signature: _____

PLEASE SEND RECORDS TO:

_____ Address listed above
_____ Pick up in office
_____ Doctor/Company: _____Phone: _____
Address: _____Fax: _____

PURPOSE OF DISCLOSURE:

_____ I AM MOVING
_____ I AM TRANSFERING PRACTICES. REASON:
_____ CONTINUING CARE/PERSONAL RECORD
_____ I AM AN OB PATIENT, LEAVING THE PRACTICE. REASON: _____

I certify that I have read, signed, and received a copy of this authorization upon my request.

Patient Signature: _____ Date: _____

Office Use Only:
Date received/ Received by: _____ / _____ Prepared by: _____
Total Fee: _____ Notified patient/Invoice sent: _____
Date Mailed/faxed/Picked up/Emailed: _____

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