ASSOCIATES IN WOMEN'S CARE, P.C.
AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION
Phone: (719) 591-6666 Fax: (719) 573-0731
This release expires 90 days from the date of signature or upon written notification.

Patient's Name: _____

Date of Birth: _____ Social Security Number: _____

Previous name under which records may be filed: _____

Patient's Address: _____

_____ Phone: _____

PLEASE FORWARD COPIES OF MY MEDICAL RECORDS

FROM: _____
_____
_____

TO: Associates In Women's Care, P.C.
6011 E Woodmen Rd, Suite 320
Colorado Springs, CO 80923

I authorize the health care provider to release the information specified below to the organization, agency or individual named on this request for the following reason: _____
_____.

I specifically authorize the release of information regarding the following condition(s): If these are not marked we CAN NOT release.

☐ Drug Abuse if Any

☐ Substance Abuse if Any

☐ Psychological or Psychiatric Conditions If Any

☐ AIDS/HIV if Any

We can only copy our records, we CAN NOT forward copies of your records that we have received from any other physician. You will need to obtain these records directly from the physician providing your care.

_____ All records generated in this office.

_____ Other: _____
(specific dates of treatment or specific parts of the record)

Are you leaving the practice? Yes _____ No _____

If yes, please explain: _____

I understand that when the information is released, it may be subject to re-disclosure by the recipient and may no longer be protected Personal Health Information (PHI).

Patient Signature: _____ Date: _____
(or legally authorized representative)

Relationship to Patient if legal representative: _____