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: ____________

Doctor name:__________________ Approximate last visit date:__________________

I specifically authorize Associates in Women's Care, PC to release my Medical Records as described on this form to the recipient listed below. Will your records be a) mailed or b) picked up?

Please release my Medical Records to:

Name: ______________________________________

Address: ______________________________________

City: ____________________ State: ________ Zip: ______

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)

Please release all information except the following. If these are marked we WILL NOT release.

- ☐ Drug Abuse if Any
- ☐ Substance Abuse if Any
- ☐ Psychological or Psychiatric Conditions If Any
- ☐ AIDS/HIV if Any

Are you leaving the practice from which you are requesting records from? Yes ________ No ________

If yes, please explain: ______________________________________

Request for medical records may require up to 10 days to process. Our charge for copying medical records is $5.00 for 1-5 pages and $14.00 for 6-10 pages. Over 11 pages there will be a charge of $.50 per page and over 40 pages there will be a charge of $.33 per page. There is no charge for records sent directly to another physician.

Patient Signature: ______________________________ Date: ________
(or legally authorized representative)

Relationship to Patient if legal representative: ____________________