

Greensboro Women's Health Care, PA

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

It is the policy of *Greensboro Women's Health Care, PA* to provide one copy of the last two office visits free of charge to current patients. If you require copies of additional medical records there is a \$10.00 handling fee plus a fee per copy. Our copying fees are: .75 per page for pages 1-25, .50 per page for pages 26-100, .25 per page for pages over 100. Once we receive your handling fee, your physician will evaluate your entire chart. At that time we will contact you to let you know how much your copying fee will be.

Every effort is made to process your request in a timely fashion. However, you should allow (7) seven working days for the processing of medical records. We prefer you pick up your records personally to prevent them from getting lost or misdirected.

I, _____, hereby authorize *Greensboro Women's Health Care, P.A.* to release my medical records to:

Name: _____ Phone: _____

Address: _____ Fax: _____

Covering the period from: _____ to _____.

I further authorize release of the following confidential records:

Records of treatment for sexually transmitted diseases, drug or alcohol abuse, or psychiatric illness:
_____ YES _____ NO

Records of testing, diagnosis, or treatment of HIV, HIV-related illness, AIDS, and AIDS-related diseases:
_____ YES _____ NO

I may revoke this authorization in writing at any time except to the extent that action has already been taken. No further information shall be released without additional written consent.

I understand that I am not required to give this consent, and that I can refuse without any prejudice to my future medical treatment.

Patient Signature: _____ Date: _____

Patient SSN: _____ Patient DOB: _____

Witness: _____ Date: _____