

*Greensboro Women's Health Care, P.A.
719 Green Valley Road, Suite 101
Greensboro, North Carolina 27409-7041
Phone: (336) 370-0277*

RELEASE OF MEDICAL RECORDS

I, _____, give permission to:

Practice Name: _____

Phone #: _____ **Fax #:** _____

to release information including reports, history, and physical condition pertaining to me to:

*Greensboro Women's Health Care, P. A.
719 Green Valley Road, Suite 101
Greensboro, NC 27408-7041*

FAX: (336) 333-9757

Records requested include:

- Specific records regarding: _____
- Entire chart from: _____ to _____
 - with the following exclusions: _____

Patient's initials: _____ I give permission to release information regarding **STD'S**.

Patient's initials: _____ I give permission to release information regarding **psychological history**.

Patient's Date of Birth: _____ **Patient's Chart #:** _____

Other Names Used: _____

Husband's Name: _____

Patient's Signature: _____ **Date:** _____

Witness: _____ **Date:** _____