# AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's Name: _____ Date of Birth: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

I, _____, hereby authorize:

Facility Name: _____

Address: _____

Phone: _____ Fax: _____

**This authorization is for release of medical records, I understand that I am giving my permission to release copies of information in my medical record that may include information relating to psychiatric treatment, drug/alcohol treatment, AIDS/HIV testing and testing/treatment of sexually transmitted disease(s).**

**Please release the following information as requested below:**

_____ Office Notes (dates): _____

_____ Operative Reports (dates): _____

_____ Pathology Reports/Laboratory Results (dates): _____

_____ X-ray and Imaging Reports (dates):_____

_____ Other (description/dates): _____

_____

_____ **Please mail the authorized information to:**

**Women's Cancer and Wellness Institute**
**1401 Johnston Willis Drive, Suite 1100**
**North Chesterfield, VA 23235**

_____ **Please fax the authorized information to:** **(804) 323-5070**

Purpose of Disclosure: _____ Personal _____ Continuing Care _____ Other: _____

**I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information disclosed may be subject to re-disclosure by the person or facility receiving it, and would then no longer be protected by federal regulations. I understand that the Women's Cancer and Wellness Institute may not condition its providing of health care on whether copies to individuals or organizations as I request.**

Patient Signature: _____ Date: _____

Witnessed by: _____

Witness Signature: _____ Date: _____