Women's Cancer &Wellness Institute

Release of Information

Patient Name: _____
Date of Birth: ____/____/_____ Last 4 of SSN: _____

I, _____, hereby authorize.

Women's Cancer and Wellness Institute to release my medical records/imaging to one of the following:

__To Release Information to:
_____
_____
_____

__Release to Patient

I would like my medical records to be:

___ Faxed to: _____
___ Mailed to: _____
_____

___ Pick up personally.

Purpose of disclosure: ___Continued Medical Care ___Disability ___ Personal use.

___Other: _____

I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with a legal claim. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following: I understand the information to be release or disclosed may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.

_____ _____
Patient Signature Date

Randal J. West, MD
FACOG

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