**PHYSICIANS FOR WOMEN OF GREENSBORO**
802 Green Valley Road Suite 300, Greensboro, NC 27408
Telephone# 336-273-3661 / Fax# 336-273-9438 or 336-574-0731
mrecords@physiciansforwomen.com

# AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name:_____
FIRST MI LAST MAIDEN / ALTERNATE

Date of Birth:_____/_____/_____ Last four SSN: _____MRN:_____
Mo/Day/Yr. USED FOR VERIFICATION ONLY OFFICE USE ONLY

Mailing Address:_____
Street/POB City St. Zip

Phone Number:_____Email:_____

| REQUEST RECORDS FROM: | SEND RECORDS TO: |
|---|---|
| | |
| Name of Practice/ Physician *PLEASE BE SPECIFIC | Name of Practice/ Physician *PLEASE BE SPECIFIC |
| Street Address / City / State | Street Address / City / State |
| Phone Fax | Phone Fax |

_____Entire Record _____Specific date(s) of service_____
_____Office notes _____Pap Smear _____Ultrasound _____ Mammogram
_____Bone Density _____Pathology _____Lab reports _____ Radiology
_____Hospital records _____Other:_____

_____ I do _____I do not authorize release of information related to AIDS (acquired immunodeficiency syndrome) or HIV (human immunodeficiency virus) infection, sexually transmitted disease(s), psychiatric care and/or psychological assessment and/or treatment for alcohol and/or drug abuse.

PURPOSE OF DISCLOSURE:

_____Update record with PCP _____Moving _____Personal _____Change Provider
_____Worker's Comp/Disability _____Legal _____Insurance
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 the cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or facility receiving it and would then no longer be protected by this release. I understand the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

_____ _____
Signature of Patient or authorized representative Date

Please provide the best telephone number to contact you in the event of a question:_____

***There may be a charge; please be specific about what records are needed.***
**Per NCGS § 90-411, there is a charge for the transfer of your records due at time of service.**
**Pages 1-25 $0.75 per page; pages 26-100 $0.50 per page; pages over 100 $0.25 per page.**