BROOKWOOD WOMEN'S HEALTH, P.C.

Medical Records Request Form

Request Date: _____

To: _____

Address: _____

_____

City/State/Zip : _____

I hereby authorize the use or disclosure of my individually identifiable protected health information ("PHI") as described below. This authorization includes any information relating to drug and/or alcohol abuse/treatment, communications with psychiatrists or psychologists or records pertaining to sexually transmitted diseases, if they are a part of my medical record. I understand that this authorization is voluntary. Once this information has been disclosed, it may be subject to re-disclosure and no longer protected by federal privacy regulations.

(check each that apply):

_____ Please release my complete medical records to Brookwood Women's Health, P.C.

_____ Please release my last appointment's notes/labs to Brookwood Women's Health, P.C.

_____ Please release my pap smear, labs and office notes to Brookwood Women's Health, P.C.

_____ Please release only my immunization records to Brookwood Women's Health, P.C.

_____ Other: _____

This authorization will expire ____

If I fail to specify an expiration date, this authorization will expire six months from the date on which it was signed.

Send these records to:

Brookwood Women's Health, P.C.
2006 Brookwood Med Ctr Dr, Suite 202
Birmingham, Al 35209
(205) 397-8850 Fax: (205) 397-8855

[ ] Jack Freeman, M.D.
[ ] John Morgan, M.D.
[ ] Jamie B. Routman, M.D.
[ ] Heidi K. Straughn, M.D.
[ ] Heather N. Deisher, M.D.

My Information: ***PLEASE PRINT***

Name: _____
First **Middle Initial** **Last**

SS#: _____ **DOB**: _____

I understand that I may revoke this authorization at any time by notifying the Privacy Officer, Mandy Phillips, in writing, but if I do, it will not have any affect to the extent Brookwood Women's Health, P.C. took action in reliance on the authorization.

Signature of Patient _____ **Date**:_____

Phone: ( ) _____ **Alternative Phone**: ( ) _____

Signature of Witness: _____