BROOKWOOD WOMEN'S HEALTH, P.C.

Medical Records Request Form

(FAX: 205-397-8855)

Request Date: _____

To: Brookwood Women's Health, P.C.

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 to protected by federal privacy regulations.

(check each that apply):

_____ Please release my complete medical records.

_____ Please release my last appointment's notes/labs.

_____ Please release my pap smear, labs and office notes.

_____ Please release only my immunization records.

_____ 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: _____

_____

_____

_____

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: _____