Medical Records Release Form

Request Date: ___________________________

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

Fax: **(205) 397-8855**

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 (date) ______________________________________

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 Gardner, 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: ____