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 (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: _____