

ANEW Gynecology and Women's Health, P.C.

Elvia A. Greathouse, MD

Authorization for Release of Medical Records

Please send a copy of this release with the requested records.

PATIENT INFORMATION (Please print)			
Patient Name		Date of Birth	Social Security Number
Address	City	Zip	Phone

RELEASE FROM: [Name of physician or facility releasing information]

I authorize release of my medical record from

Physician/Facility			
Address	City	Zip	Phone

RELEASE TO: [Name of physician or facility receiving information]

Please send my medical record to:

Physician/Facility ANEW Gynecology and Women's Health			
Address 415 W. 1 st St.	City Bloomington, IN	Zip 47403	Phone 812-333-9650

RELEASE INFORMATION

Reason: <input type="checkbox"/> Change of insurance	<input type="checkbox"/> Transfer of care	<input type="checkbox"/> Personal file
<input type="checkbox"/> Moving out of area	<input type="checkbox"/> Specialist consultation	<input type="checkbox"/> Legal

Please release the following (check all that apply)

RECENT H&P	LAST THREE VISITS
LAB REPORTS	X-RAY REPORTS
HOSPITAL REPORTS	OTHER:

- Please allow 15 days for processing.
- Incomplete information will delay processing.
- Use of this information for any other than the stated purpose is prohibited.
- This information is for the use of the designated recipient only and cannot be provided to any other agency.

CONSENT

I authorize the release of all information indicated, and I am aware that the records released may contain information relating to psychiatric or psychological testing, physical abuse, or drug and alcohol abuse.

I authorize the release of HIV/HTLV/AIDS test results.

I understand that I may be charged for copies provided. (See reverse side.)

YES NO Initials

Signature of patient, parent, guardian, conservator, or patient representative (Please circle.)	Date
Witnessed by	Date

Note: This consent is valid for 90 days. It may be revoked by the signer at any time.