PHYSICIANS TO WOMEN, INC.

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Identification:

Printed Name_____ Birthdate _____/_____/_____

Address_____ Social Security _____-_____-_____

_____ Phone number (_____) _____-_____

INFORMATION TO BE RELEASED BY :

_____
Physician or Facility

_____
Street Address

_____
City, State, Zip

(_____) _____-_____
Phone Number

(_____) _____-_____
Fax

INFORMATION TO BE RELEASED TO:

_____
Physician or Facility

_____
Street Address

_____
City, State, Zip

(_____) _____-_____
Phone Number

(_____) _____-_____
Fax

INFORMATION TO BE RELEASED – COVERING THE PERIODS OF HEALTH CARE:

From (date)_____/_____/_____ To (date) _____/_____/_____

Please check type of information to be released:

- ☐ Complete Health Record
- ☐ Laboratory Test Results
- ☐ Radiology Report
- ☐ Other (please specify)_____
- ☐ Pathology Report
- ☐ Complete Billing Record
- ☐ EKG Report

Purpose of request:

- ☐ Treatment or Consultation
- ☐ At Patient's Request
- ☐ Billing Claims or Payment
- ☐ Other (please specify)_____

If requesting my own medical records or if I am leaving the Practice, I understand and agree that I am financially responsible for the following fees associated with my request. Copying charges, which include cost of supplies and labor related to the production of my information are as follows:

$10.00 processing and handling fee + $0.50 per page for the first 25 pages and $0.25 each additional page.

Payment must be made at time of picking up or before faxing/forwarding to another Practice, if you are leaving this one.

Signature of Patient or Legal Guardian _____ Date_____/_____/_____

Printed Name of Patient _____

Witness _____

FORMS WILL BE READY IN TEN (10) BUSINESS DAYS FROM DATE RECEIVED
IF THIS FORM IS NOT COMPLETELY FILLED OUT IT WILL CAUSE A DELAY

Updated 8/29/11