Women First OB/GYN P.C.

Namrata Choudhary, M.D., F.A.C.O.G.
Laurie Niergarth, C.N.M.

Obstetrician & Gynecologist

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____ DOB: _____

Address: _____ city _____ zipcode _____

SSN: _____ Phone No:_____

I, _____hereby authorize

_____

Phone Number : _____ Fax: _____

to release my medical records to :

WOMEN FIRST OB GYN P.C.

1860 Town Center Drive Suite 140 Reston, VA 20190

Phone: (703) 773-0300 Fax: (703) 773-0305

___ Complete Medical Records

___ X-ray/Sonograms from _____ to _____

___Labs from _____ to _____

___Admission and Discharge Summary (DOS: _____)

___ Operative Reports (DOS: _____)

___ Other : _____

If you have any questions regarding the information to be disclosed, please contact the office directly.

Signature:_____ Date:_____