Women First OB/GYN P.C.

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Obstetrician & Gynecologist

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name:_____Date of Birth:_____

Phone Number:_____ SSN #:_____

I request and authorize **WOMEN FIRST OB/GYN P.C** to release healthcare information of the patient named above to:
Name: _____

Address:_____

City:_____ State:_____Zip Code:_____

Phone number: _____ Fax number: _____

This request and authorization applies to:
☐Entire medical record
☐Please release ONLY the following information:
☐Lab results (Date/type of labs) : _____
☐ Imaging reports (Date/Type of image):_____
☐ Office/Doctor notes (Date of service):_____
☐Other (Please describe):_____

The identified information will be used for the following purpose:

☐ Personal ☐Transfer ☐Other (Please describe:_____)

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

☐ Yes ☐ No I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the practice. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Please understand that the office has a right to charge for medical records .
Virginia
VA Code § 32.1-127.1:03. Health records privacy.
If an individual or his agent / attorney requests a copy of his own medical records, the health care entity may impose a reasonable cost-based fee, which shall include the cost of supplies for and labor of copying the requested information, as well as postage where applicable.

Print Patient Name:_____

Patient Signature:_____

Date_____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.