DOUGLAS WOMEN'S CENTER

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AUTHORIZATION AND REQUEST FOR RELEASE OF MEDICAL RECORDS
A MINIMUM OF 72 HOURS ADVANCE NOTICE REQUIRED TO PROCESS THE REQUEST

Patient Name: _____DOB: _____

Current Address: _____

Home#: _____ Cell #: _____ Work #: _____

Reason for Request:

□ Selected New Physician in the Area □ Second Opinion Consult □ Change of Insurance

□ Moving out of town □ Other: _____

I, _____, hereby authorize you to furnish to: _____

By Method of: (Please Check One) **FAX:____** **MAIL:____** **PATIENT WILL PICK UP RECORDS:____**

Recipients Address: _____

Phone #: _____Fax #: _____

Portion of Records to be Released: □ Entire Medical Record **OR** □ Other (please specify) _____

I understand these records may contain information from other health care providers, as well as information that is administrative in nature. I specifically consent to the release of any information contained in the medical record that may relate to infection with Human Immunodeficiency Virus (HIV), AIDS or related conditions.

I understand that you have no responsibility for the use of distribution of this information by the party to whom it is released. I release you from all liability that may arise from your compliance with this request to release records.

I authorize you to transmit this information by facsimile (fax) transmission, if I so desire, and release you from any liability for breach of confidentiality, misdirection of transmission or failure to receive transmission if my records are transmitted by fax.

_____ _____
Patient/Legal Representative Signature Date

Patient unable to sign because _____

Relationship of Legal Representative: _____

Revised 07-18-2018