

WOMEN'S HEALTH PARTNERS, LLC

DIPLOMATES OF THE AMERICAN BOARD OF OBSTETRICS & GYNECOLOGY

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CONSENT TO RELEASE & OBTAIN PATIENT RECORDS

I hereby authorize Women's Health Partners, LLC

_____ To RELEASE copies of my medical records to:

_____ To RECEIVE copies of my medical records from:

Name: _____

Address: _____

Phone: _____ Fax: _____

I understand that my records may contain information pertaining to my diagnosis or treatment of my medical, psychiatric, AIDS/ARC/HIV testing, alcohol or drug abuse condition. I also understand that any topic discussed during my medical treatment was documented, and therefore, will be released.

_____ Send all of my records

_____ Send only the following records: _____

Patient Name: _____

SS #: _____ Date of Birth: _____

Patient Address: _____

I understand the following:

- a. I may revoke this authorization at any time by providing written notice to the practice.
- b. I may not be able to revoke this authorization if the practice has already taken action utilizing this authorization or if the authorization was obtained as a condition of obtaining insurance coverage.
- c. The practice will not condition treatment or payment based on my signing this authorization.
- d. I am signing this authorization freely.
- e. No one has pressured me to sign this authorization.
- f. The information disclosed in this authorization may be subject to re-disclosure by the practice and no longer protected by federal law.
- g. I acknowledge that I have had an opportunity to review this authorization and understand the intent and the use.

Signature: _____ Date: _____

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