Authorization to Release Medical Records

I hereby authorize Creating Harmony Women's Healthcare to disclose the following designated medical information obtained during the course of my evaluation and/or treatment.

Patient's Name (please print): ____

Date of Birth: ______________________________ SSN: ____________________________

Signature: ____ Date: _____________________

Information to Release:

I request that the information to be used or disclosed consist of the following:

Check all that apply:

☐ All medical records from Creating Harmony Women's Healthcare
☐ Imaging reports
☐ Laboratory reports
☐ Surgical reports
☐ Other (please specify):

____

☐ Sensitive information regarding HIV/AIDS, or treatment for substance abuse and/or mental health
☐ I do NOT authorize the release of sensitive information re: HIV/AIDS, or treatment for substance abuse and/or mental health

Release information to:

Name: _________________________________ Address: _______________________________

Phone: _________________________________ _______________________________

Fax: ___________________________________ Email: _________________________________

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