PHYSICIANS TO Women INC.

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Identification:

Printed Name_____ Birthdate _____/_____/_____

Address_____ Social Security _____-_____-_____

_____ Phone number (_____) _____-_____

INFORMATION TO BE RELEASED BY:

_____
Physician or Facility

_____
Street Address

_____
City, State, Zip

(_____) _____-_____
Phone Number

(_____) _____-_____
Fax

INFORMATION TO BE RELEASED TO:

_____
Physician or Facility

_____
Street Address

_____
City, State, Zip

(_____) _____-_____
Phone Number

(_____) _____-_____
Fax

INFORMATION TO BE RELEASED – COVERING THE PERIODS OF HEALTH CARE:

From (date)_____/_____/_____ To (date)_____/_____/_____

Please check type of information to be released:

- ☐ Complete Health Record
- ☐ Laboratory Test Results
- ☐ Radiology Report
- ☐ Other (please specify)_____
- ☐ Pathology Report
- ☐ Complete Billing Record
- ☐ EKG Report

Purpose of request:

- ☐ Treatment or Consultation
- ☐ At Patient's Request
- ☐ Billing Claims or Payment
- ☐ Other (please specify)_____

I understand and agree that I am financially responsible for the following fees associated with my request: copying charges, which include the cost of supplies and labor, and postage related to the production of my information. First 25 pages, $.50 per page, $.25 each additional page. Payment must be made before records are copied.

Signature of Patient or Legal Guardian _____ Date_____/_____/_____

Printed Name of Patient _____

Witness _____

FORMS WILL BE READY IN FIVE (5) BUSINESS DAYS FROM DATE RECEIVED
IF THIS FORM IS NOT COMPLETELY FILLED OUT IT WILL CAUSE A DELAY

Updated 8/29/11