

**Women's Health Alliance, P.A. pka
Wilkerson Obstetrics & Gynecology
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

(Print Patient's Full Name)

Birth Date (Mo/Day/Yr)

(Street Address)

Social Security Number

(City, State, Zip code)

Phone (Home)

At the request of the individual, I _____, do hereby authorize **Wilkerson OB/GYN** to release:
(Patient's Name)

DISCHARGE SUMMARY

HISTORY & PHYSICAL

PROGRESS NOTES

OPERATIVE NOTES

PATHOLOGY REPORTS

LABORATORY REPORTS

RADIOLOGY REPORTS

ECG/EEG/CARDIC CATH

EMERGENCY REPORTS

OTHER _____

From the time period of _____ to _____

_____ I do _____ I do NOT authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

INFORMATION RELEASE TO: _____

Name of Company/Agency/Facility/Person

Phone Number

Street Address

Fax Number

City, State, Zip code

PURPOSE OF DISCLOSURE:

REFERRAL TO SPECIALIST

LEGAL INVESTIGATION
OTHER (SPECIFY) _____

INSURANCE

DISABILITY DETERMINATION

WORKERS COMP

PERSONAL

CHANGE OF DOCTOR

CONTINUING CARE

Please provide current daytime telephone number in the event we need to contact you: _____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized is furnished may not condition its treatment of me on whether or not I sign the authorization.

**Signature of individual or guardian or
Personal Representative of patient's estate**

Date

PLEASE NOTE: THERE IS A CHARGE FOR MEDICAL RECORDS WHEN REQUESTED FOR PERSONAL REASONS OR PERMANENT TRANSFER. HEALTHPORT HAS BEEN CONTRACTED TO PROVIDE THIS SERVICE AND WILL INVOICE YOU DIRECTLY. PLEASE ALLOW TWO (2) WEEKS FOR RECORDS TO BE PROCESSED AND MAILED.

MEDICAL INFORMATION RELEASED BY HEALTHPORT

ENTIRE _____ LAB _____ EKG _____
DS _____ EKG _____ IMMUNE _____
OP _____ X-Ray _____ CLINIC _____
HP _____ PATH _____ OTHER _____

ROI SPECIALIST DATE

NUMBER OF PAGES