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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, _____, hereby authorize Women First Health Services to:
(PATIENT NAME)

_____Release My Information To: **_____Get My Information From:**

Name:_____Phone:_____Fax:_____

Address:_____

Please Check:
_____ All Medical Records (From _____To_____)
_____ All Obstetrical Records (From _____To_____)
_____ Other (please specify) _____

_____

_____ Entire Medical Record (with possible exclusion as indicated below)

___ Exclude information related to the treatment for substance abuse or dependency, psychiatric or mental health treatment, information related to testing or treatment for HIV/AIDS and hepatitis

I understand that signing this authorization includes, but is not limited to, the following:

- Releasing or obtaining medical records pertaining to human immunodeficiency syndrome, AIDS, AIDS related Complex ARC, and all forms of hepatitis.

Patient Signature Date

Patient Social Security Number Patient Date of Birth

****Please note the following fees must be collected before records can be released: $1.00 per page for the first 20 pages; $.50 for pages 21-50; $.20 for pages 51 and over; postage and shipping (if applicable); actual cost of retrieving records 7 years or older not stored on-site (if applicable); $20 request fee (if applicable).**