Friendship Heights
Women's Health Associates
AN ADVANTIA HEALTH PRACTICE

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS AND INFORMATION

RELEASE TO: _____

PHONE: _____ FAX: _____

RELEASE FROM: _____

PHONE: _____ FAX: _____

PATIENT NAME: _____

DOB: _____ PHONE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

I, _____ AUTHORIZE AND REQUEST YOU TO PROVIDE A COPY OF:

_____ ALL INFORMATION RELATED TO MY PAST AND PRESENT MEDICAL HISTORY DIAGNOSIS AND TREATMENTS.

_____ MEDICAL RECORDS FROM SERVICE DATES: _____ TO _____

_____SPECIFIC RECORDS OR TESTS _____

*PLEASE STATE THE REASONS FOR THE REQUEST OR TRANSFER:

I understand the medical records to be released may contain information related to HIV status, AIDS, sexually transmitted disease, alcohol, drug abuse and mental health services, I also understand that under Maryland law there may be a charge for preparing and copying all or any medical records. This authorization for discloser is valid for a period of one year or until (date) _____, whichever is sooner, and may be withdrawn by me at any time except during action taken in response herein.

PLEASE ALLOW 2 TO 3 WEEKS TURN AROUND TIME.
THE REQUEST MUST BE IN WRITING. THERE WILL BE A FEE FOR ALL RECORDS.

SIGNATURE: _____ DATE: _____

WITNESS SIGNATURE: _____ DATE: _____