Women's Health Care Associates
Normal and High Risk Obstetrics, Gynecology, and Infertility
7720 South Broadway, Suite 440
Littleton, Colorado 80122
303-795-0890

AUTHORIZATION FOR MEDICAL RECORDS TO BE RELEASED

I hereby authorize: Women's Health Care Associates, PC
7720 S. Broadway, Suite 440, Littleton, CO 80122
Phone: 303 795-0890 Fax: 303 795-3568

To Release Medical Records on:

Patient Name: _____Date of Birth: _____
Address: _____
_____
Phone: _____ Cell: _____
Social Security # _____

Information to be disclosed:

- ☐ Complete Medical Records
- ☐ Progress Notes
- ☐ Pathology Reports
- ☐ Other(specify) _____
- ☐ Labs
- ☐ Mammograms
- ☐ Pregnancy Record(s)

Please provide records dated from _____to _____

This information is to be disclosed to:

Doctor's Name: _____
Address: _____
_____
Phone: _____ Fax: _____

I understand in signing this release form, I give my permission to release my confidential information to the name above. My signature also authorizes the release of any information relating to AIDS or HIV testing, alcohol use, or mental status contained in my medical records.

Signature_____Date _____

To further help us in storing your records, please check the appropriate statement:

- ☐ Please keep my records current, as I am still a patient in your care.
- ☐ Please purge my record, as I am transferring care.

Reason for leaving the practice: _____