



A HERA WOMEN'S HEALTH CENTER OF EXCELLENCE

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AUTHORIZATION FOR DISCLOSURE OF MEDICAL RECORDS

1. REGARDING PATIENT

NAME - LAST, FIRST, MI		
STREET ADDRESS		
CITY	STATE	ZIP CODE
SSN	DOB	

2. RECORDS RELEASED FROM

3. RECORDS RELEASED TO

NAME			NAME:		
STREET ADDRESS			STREET ADDRESS:		
CITY	STATE	ZIP	CITY	STATE	ZIP
PHONE #	FAX#		PHONE #	FAX #:	

4. INFORMATION TO BE RELEASED

- Complete Copy of All Records
- Counseling & Consultation Visits
- Lab Reports
- Records Pertaining to Pregnancy
- Pap Smear History
- Other (Specify) _____

5. PURPOSE OF NEED FOR DISCLOSURES (check all that apply)

- Transferring Care
- Legal Investigation
- Further Medical Care
- Application for Insurance
- Legal Investigation
- Personal
- Disability
- Other _____

No copy fee will be charged if records are sent directly to another physician or health care facility. You must pay a copy fee if you are requesting your records for any other reason.

I authorize the release of my medical records in accordance with the specification listed above. A faxed or emailed copy of this consent shall be valid as the original.

Signature of Patient _____

Date _____

THIS FORM MAY BE FAXED TO 702-565-5027 OR EMAILED yrodriguez@legacyforwomen.com