Exceptional Care for Women
Authorization to Release Healthcare Information
Phone: (719) 884-9962 Fax: (719) 884-9963

This release expires 90 days from the date of signature or upon written notification.

Patient's Name: _____Previous Name: _____

Date of Birth: _____ Social Security Number: _____ Phone: _____

Patient's Address: _____

_____

Doctor Name: _____ Approximate last visit date: _____

I specifically authorize Exceptional Care for Women, to release my Medical Records as described on this form to the recipient listed below. Will your records be ☐ **Mailed** ☐ **Picked Up?**

Please release my Medical Records to:

Name:_____

Address: _____

City: _____ State: _____ Zip:_____

We can only copy our records, we **CAN NOT** forward copies of your records that we have received from any other physician. You will need to obtain these records directly from the physician providing your care.

____☐ Records generated in this office.

____☐ Other: _____
(specific dates of treatment or specific parts of the record)

I specifically authorize the release of information regarding the following condition(s): If these are not marked we **CAN NOT** release.

____☐ Drug Abuse if Any
____☐ Psychological or Psychiatric Conditions if Any
____☐ Substance Abuse if Any
____☐ AIDS/HIV if Any

Are you leaving our practice? Yes ____☐ No ____☐

If yes, please explain: _____

Request for medical records may require up to 10 days to process. Our charge for copying medical records is $14.00 for the first 10 pages and $.50 for pages 11-40 and $.33 for each additional page. There is no charge for records sent to another physician.

I authorize Exceptional Care for Women to release the information specified below to the organization, agency or individual named on this request.

Patient Signature: _____Date: _____
Relationship to patient if legal representative: _____