The Women's Group PC
Authorization to Release Medical Information

Completing and signing this form does not allow any information to be released except that which is specifically described below:

From: The Women's Group PC	**To:**
To Address:	

Your name: _____DOB:_____

Your address if not listed above _____

_____Your Phone: _____

Any other names you may have used:_____

I Authorize The Women's Group to Release:

____ Release my records to another provider listed above. Our policy is to include the last 7 years. No charge.

Exclude Records Related to: ____ HIV/AIDS ____ Drug Use ____ Alcohol Use ____ Psychiatric care

_____ Release records to me. Fee $14.00 for the first 10 pages, plus 50 cents/page for pages 11-40, then 33 cents/page for pages 40+. **Order a CD rather than paper for a $4.00 discount. $5 replacement of lost CD.**

Include: ___ last 3 years ___ last 7 years ___ all records

Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

YOU MUST SIGN!

_____ _____

Patient or legally authorized individual signature: Date

_____ _____

Printed name if signed on behalf of the Patient Legal relationship

Records are sent directly to another provider at no charge. **Allow 1 Month for delivery.**

Credit card payment only. Please email Info@thewomensgroup.com to pay by check.

Name on Card:		Card #		
Expiration:	CV#:	**CD (save $4)**	**OR**	Paper
Email:				
Card Address				
Signature of Cardholder:				

The Women's Group PC - www.thewomensgroup.com

PO Box 744 Sedalia, CO 80135