WOMENS HEALTH GROUP INC

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT NAME____

PATIENT DOB ____

PATIENT SS# ____

PHYSICIAN REQUESTING RECORDS ______________________________

The patient named above is requesting that a copy of her history, operative reports, last two pap smears and last two mammogram reports (if no history of abnormal). Also progress notes, lab reports, radiology and ultrasound reports(again last two years if no history of abnormal).
The patient acknowledges and understands that the medical record may contain information regarding psychiatric disorders, drug and alcohol abuse, hiv results, a diagnosis of AIDs or an Aids related condition and expressly consents to the release of any such information contained in the records designated above

ANY OTHER ____

PATIENT SIGNATURE ____

DATE REQUEST SIGNED____

PREVIOUS DOCTOR____

DOCTORS ADDRESS ____

CITY, STATE, ZIP ____

TELEPHONE # ____

FAX # ____

PLEASE FORWARD INFORMATION TO: WOMENS HEALTH GROUP

____ 121 Northwest Ave. Tallmadge, Ohio 44278
Phone 330–633-1350 Fax 330–633-6068

____ 919 East Turkeyfoot Lake Rd. # A Akron, Ohio 44312
Phone 330–899-9626 Fax 330-899-0234