



MEDICAL RECORDS REQUEST

Patient's Full Name _____
Any Other Names Patient May Be Listed As _____
Address _____
City, State, Zip _____
Date of Birth _____

I hereby request the following medical records in the possession of the provider, including, but not limited to, records, reports, tests or information concerning mental illness or developmental disabilities, psychotherapy notes, HIV/AIDS testing or treatment, communicable diseases, venereal diseases, substance abuse, abuse of an adult with a disability, sexual assault, child abuse and neglect, genetic testing and abortions (*if you wish to limit the material disclosed above in any way, please indicate exactly what you do not want released*):

Please initial:

- | | |
|---|--|
| <input type="checkbox"/> Complete Medical Record | <input type="checkbox"/> Emergency Reports |
| <input type="checkbox"/> Clinic Notes | <input type="checkbox"/> Lab Results |
| <input type="checkbox"/> Operative Reports | <input type="checkbox"/> Pap Smear Results |
| <input type="checkbox"/> Pathology Reports | <input type="checkbox"/> Mammogram Reports |
| <input type="checkbox"/> Ultrasound/X-Ray Reports | <input type="checkbox"/> Discharge Summaries |
| <input type="checkbox"/> Other: _____ | |

For the following dates of treatment: (for example: specific date, range of dates, all dates of service)

be released by Fax or Mail

FROM: (name)	TO: Professional Women s Healthcare, P.A.
(address)	805-B Tilghman Drive
(address)	Dunn, NC 28334
(tel. #)	Tel.: (910) 897-7711
(fax #)	Fax: (910) 897-2654

The purpose of the disclosure is: continued patient care other: _____

***This request is valid for 6 months from date of the above signature. I understand that I may change my mind and revoke this Medical Records Request in writing at any time by notifying the Privacy Officer. I understand that changing my mind will not affect my treatment. The revocation will not apply to the extent that Professional Women s Healthcare has already taken action where it relied on my permission. I understand that I have the right to inspect or copy any information used/disclosed under this authorization. I understand that I may refuse to sign this Medical Records Request, and if I do refuse, my ability to obtain treatment will not be affected unless the only purpose of treatment is to create health information for the disclosure listed above. I have read and understand this Medical Records Request and had a chance to ask questions about the disclosure of health information. I authorize Professional Women s Healthcare, P.A. to use my health information in the manner described above.

X _____
 Signature of Patient Date