Elite Women's Health

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Informed Authorization and Consent for the release of Medical Records

I hereby authorize Elite Women's Health to:

( ) **RELEASE** ( ) **OBTAIN** the medical records of: _____

whose date of birth is: _____ and date of treatment was _____.

( ) **RELEASE TO:**	( ) **OBTAIN FROM:**
_____	_____
_____	_____
_____	_____

for the purpose of: _____

Please indicate what specifically is to be released:

( ) Entire Medical Record	( ) Mammography	( ) Laboratory Tests
( ) Discharge Summary	( ) Operative Reports	( ) Pathology

( ) Other: _____

I understand that these medical records may or may not contain information pertaining to alcohol or drug abuse counseling or testing, and/or HIV/ARC testing. I do expressly and voluntarily authorize the disclosure of the said medical records to the person(s) and/or entity(ies) as stated above. This authorization/consent will remain in effect for a period of one (1) year from the date stated below, unless revoked in writing by the person to which it pertains (or his/her parent, legal guardian or legally authorized agent), to the Medical Records Department. These medical records are being disclosed under the provisions of the applicable Virginia State and Federal Law.

_____ _____

Patient Signature ***Date Signed***