Full Circle Women's Health

450 Mamaroneck Avenue, Suite 414, Harrison, NY 10528
t: 914.421.1515 f: 914.421.1501 email: medicalrecords@fullcirclewh.com

MEDICAL RECORDS RELEASE FORM

Patient Name: _____

Patient Address: _____

Home #: _____ Work #: _____ Cell #: _____

Birth Date: _____ Social Security No.: _____

Please send a copy of my medical records:

FROM: Provider's Name: _____

Practice Name: _____

Practice Address: _____

City, State, Zip: _____

Fax #: _____ Tel #: _____

TO: Medical Records
Full Circle Women's Health
450 Mamaroneck Avenue
Suite 414
Harrison, NY 10528

Please specify which medical records you want released and/or dates of service:

____ Annual exam and pap smear

____ Pregnancy/Prenatal

____ All medical records

____ Surgical records

____ Sonograms and Labs - copies of actual lab reports

____ Other

I understand that my medical records are protected under State and Federal confidentiality regulations. Disclosure of information regarding drug and/or alcohol abuse and treatment, confirmed sexually transmitted infections, including testing or treatment of HIV/AIDS and diagnosis of mental illness or psychiatric care cannot be released without my written consent.

This consent can be revoked by me at any time unless action has been taken in reliance on it. If not previously revoked, this consent will terminate in 180 days.

I further authorize and request that you accept a faxed copy of this authorization as the original.

_____ _____

Signature Date Witness Date