Womankind

The kind of health care you deserve

Medical Records Release

Patient Name: Date of Birth:

Email: Phone:

What would you like us to do? (check one)

- ( ) Request my records from another provider
- (•) Send my records to another provider

Provider Information (REQUIRED)

Please complete this section fully so we can process your request

Provider/Office Name:

Phone Number: Fax Number:

Address: City/State/Zip:

What records do you want sent/requested?

- [ ] All records
- [ ] Specific records:

(e.g., Annual exam, Pap smear, labs, etc.)

Review & Sign

I understand that the requested records may include medical history, physical exams, laboratory results (including Pap smear, biopsy, HIV, drug toxicology, Hepatitis, and STD testing), diagnostic testing, psychiatric evaluations, and other sensitive information. I authorize Womankind to release these records as requested. I understand that I may revoke this authorization at any time in writing, except to the extent that action has already been taken based on this authorization.

Patient Signature: Date:

Received by (Womankind Staff): Date:

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