# Womankind

1511 Truman Ave • Key West, FL • 33040 • Phone: 305-294-4004 • Fax: 305-294-2197 • www.womankindkeywest.org

# Authorization for Release of Medical Records

**REGARDING:** _____
Last Name First Name Middle Initial

_____
Street Address City, State Zip

_____
Date of Birth

I hereby authorize Womankind, inc. to

□ Release copies of my medical records to
□ Request copies of my medical records from

_____
Name

_____
Address

_____
City, State Zip

_____
Phone # Fax #

Records needed: _____

Reason for records release: □ moving □ insurance □ other _____

I understand that the requested records might include medical history, physical exams, laboratory results including pap smear, biopsy, HIV, drug toxicology, Hepatitis, STD testing, and any other diagnostic testing, psychiatric evaluations and other sensitive documentation. (Patient's initials: _____ )

The facility and the employees and attending clinicians are released from legal responsibility or liability for the release of the above information to the intent indicated and authorized herein.

Signature of Patient: _____ Date: _____

Witnessed by: _____ Date: _____

**Medical Records Department Only**

MAILED PICKED UP ON:_____

Staff Signature: _____