WOMEN'S HEALTH
of Central Virginia

# For WHSCV TO RELEASE RECORDS

I understand that this authorization may be revoked at any time in writing. I hereby authorize the release of the following protected health information:

**1. Please Release Records From:**

Women's Health Services of Central Virginia

Facilty/Employer

114 Nationwide Drive, Lynchburg VA 24502

Ph: (434) 239-7890 Fax (434) 237-9222

**2. To Be Sent To:**

_____
Name of Physician/Health Care

_____
Street Address

_____
City/State/Zip Code

_____
Phone Number/ Fax Number

**3. INFORMATION TO BE RELEASED:**
Please be specific regarding types of information, i.e. , diagnosis treatment, lab results, billing information may be released.

[ ] Clinic/Progress Notes [ ] Laboratory Reports [ ] Pap/Cytology/Pathology

[ ] Bone Density Reports [ ] Mammogram Reports [ ] OB Records

[ ] ALL RECORDS [ ] Other_____

**4. RECORDS FROM THE TIME PERIOD:**_____ **to** _____.
**Specify Dates**

**5. PURPOSE OR NEED FOR RECORDS:**
[ ] Further Medical Treatment [ ] Other (specify) _____

**6. PATIENT IDENTIFICATION**
**Patient Name:**
**SSN:**
**DOB:**
**Patient Address:**
**PHONE: (H) (W)**
This authorization is in force for 30 days following the date signed.

_____ **{DATESTAMP()}**
**Signature of Patient** **Date**

This Protected Health Information, once released from Women's Health Services of Central Virginia's custodial care per the instructions specified on this authorization, may be reproduced or released by the receiving entity. This subsequent reproduction/release is beyond Women's Health Services of Central Virginia's control and authority.