WOMEN'S HEALTH
of Central Virginia

WHSCV TO GET RECORDS

1. I HEARBY AUTHORIZE:

_____
Name of Physician/Health Care Facilty/Employer

_____
Street Address

_____
City/State/Zip Code

_____
Phone Number/ Fax Number

2. TO RELEASE TO:

Women's Health Services of Central Virginia

114 Nationwide Drive, Lynchburg VA 24502

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

3. INFORMATION TO BE RELEASED:

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

[ ] Hospital Records [ ] Bone Density Reports [ ] Mammogram Reports

[ ] OB Records [ ] Other_____

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

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

I understand that I am giving my permission to release information in my medical record that may include information relating to psychiatric treatment, drug/alcohol treatment, AIDS/HIV testing or treatment of sexually transmitted disease, unless indicated in the following instructions.
____(initial)

I specifically give authorization to FAX my medical informaion. I understand that risk is involved in faxing records and confidentiality at the receiving end cannot always be guaranteed. All fax information will contain a confidentiality statement and instructions for returning misdirected information.
____(initial)

_____

_____

6. PATIENT IDENTIFICATION

Name:
SSN:
DOB:
Address:

_____
Signature of Patient **Date**