Women's Cancer &Wellness Institute

Release of Information

Randal J. West, MD FACOG

Jori S. Carter, MD FACOG

Ruth B. Felsen, MD FACS

Diane R. Cox, MD FACS

Patient Name: _____

Date of Birth: ____/____/_____ Last 4 of SSN: _____

I, _____, hereby authorize.

Women's Cancer and Wellness Institute to release my medical records to one of the following:

___To Release information to:

_____

_____

_____

___Release to Patient

I would like my medical records to be:

___Faxed to: _____

___Mailed to:_____

_____

___Pick up personally

Purpose of disclosure: ___Continued Medical Care ___Disability ___Personal use

Records Requested: ___All Records ____Dates: _____ to _____

___Other: _____

I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with a legal claim. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following: I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.

_____ _____

Patient Signature Date

1401 Johnston Willis Drive, Suite 1100, North Chesterfield, VA 23235, Fax: 804-323-5070

9101 Stony Point Drive, Suite 3300, Richmond, VA 23235, Fax: 804-272-0526

Ph: 804-323-5040 womenscancerandwellness.com