AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION
The Women's Health Group, P.A. --- 1620 Charles Place, Manhattan, KS 66502
Phone: 785-776-1400 --- Fax: 785-776-7392

Failure to fill out this form completely and/or appropriately may prevent or delay release of information.

Patient Information
Name: _____ DOB: _____
Address: _____ SSN: _____
_____
Previous Last Name(s): _____

******Please note: a separate authorization must be filled out for each provider you wish to request from/send records to******

I authorize and request:

Facility or person: _____
Address: _____
Phone: _____
Fax: _____

To release my medical records to:

Facility or person: _____
Address: _____
Phone: _____
Fax: _____

Information to be released --- **CHOOSE ONLY THE FIELDS THAT APPLY**:

___ Complete health record

___ Records within a certain time period: from _____ to _____

___ Office notes from _____ to _____

___ Labs from _____ to _____

___ Radiology from _____ to _____

___ Hospital records from _____ to _____

___ Other --- *please specify* _____

****Please note: Requests may not be made for **future** dates of service.****

This consent is subject to written revocation by the undersigned at any time except to the extent that action has been taken, and if not earlier revoked, this consent shall become invalid one year from the date of signature. I hereby release all parties from any/all legal liability that may arise from the release of this information to the party named above. I understand that I may review the disclosed information by contacting the physician, institution, or agency named above. I understand that I have the right as a patient to inspect the disclosed material.

This authorization will expire on the following date or condition: _____

_____ Date: _____
Signature of Patient or Legal Guardian
Relationship to patient (if other than self): _____

Office use only:
Received on: _____
Staff initials: _____