PHYSICIANS FOR WOMEN

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Authorization for release of Medical Information

I, ______________________________, authorize ____
(Patient) (Provider/Office/Facility)

To release the following medical information to ____

At ____
(Address must be provided in order to complete request)

Please select:

_____ any and all medical records as of this date
_____ any medical records pertaining to specific surgery/visit/delivery (date _____________)
_____ lab results only
_____ other records (please specify) ____

Select delivery option:

_____ personally pick up
_____ mail
_____ fax/email/other ____

* By Alabama law, we have **30** days to complete the records request from the date the request was originated. If the chart. is in an off site location, we have **60** days to complete the request.
* **Charges for medical records are the patient's responsibility and must be paid before records are released. There may be additional charges for the duplication of records previously requested.**
* This release is effective for twelve months from the date of execution; however, you may revoke the request at any time by providing notice in writing.
* By signing below, you understand the policies and acknowledge the request you have made for the release of medical records.
* Physicians For Women, its employees, officers, and providers are herby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

____ Date of Birth: _________________________
(Patient's printed name)

____ Date: _________________________
(Patient's Signature/or Guardian, if a Minor)

287 Mitylene Park Drive
P.O. Box 240488
Montgomery, AL 36117
P 334-290-4200
F 334-290-4190

Prattville Medical Park
635 McQueen Smith Road, Ste E
Prattville, AL 36066
P 334-491-4200
F 334-491-4201