



Release of Information Authorization

I hereby authorize: Complete Care Center for Women / Complete Care Birthing Center

Dr. Carpenter Dr. Diaz Jessica Jordan, CNM

7107 Jahnke Rd.
Richmond, VA 23225
Phone: (804) 320-4967
Fax: (804) 320-7130

To release the medical information from the records of:

Patients Name / DOB SSN

To authorize the release of HIV/AIDS testing and/or treatment.
Initial

To authorize the release of Lab Testing.
Initial

To authorize the release of OB/GYN records
Initial

Other:
Initial

The information is to be released to:

Name

Address (City, State, Zip)

Phone Fax

The information to be released is (Itemize portions of the record and specify time period):

[Blank lines for itemizing portions of the record]

- Notice:
A. By signing below you are giving your permission to the above named provider to disclose confidential health care records, which may include HIV/AIDS testing and/or treatment, Lab testing, and/or OB/GYN records.
B. The person or identity who receives the information to which the authorization pertains, may not redisclose the information to anyone else without your separate written consent, except as permitted by law.
C. You have the right to revoke this consent but your revocation is not effective until it is delivered in writing to the healthcare facility in possession of your records
D. This consent will be filled with the original record.
E. This authorization will expire ninety (90) days from the date of signature.

Patient's Signature/Responsible Party Date Witness Date