Complete Care Center for Women

S. Diaz, M.D.
J. Carpenter, M.D.

Obstetrics Gynecology Family Practice

Release of Information Authorization

I hereby authorize: Complete Care Center for Women, LLC
Dr. Carpenter
Dr. Diaz
7107 Jahnke Rd.
Richmond, VA 23225

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):
_____
_____
_____

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