



Release of Information Authorization

I hereby authorize _____ of _____
Physician Healthcare Facility

Address (City, State) () - () - Phone Fax

to release the medical information from the records of:

Patients Name / / DOB - - SSN

To authorize the release of Psychiatric treatment information. Initials

To authorize the release of Drug/Alcohol information. Initials

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

To authorize the release of OB/GYN records. Initials

The information to be released to:

Complete Care Center for Women
7107 Jahnke Rd.
Richmond, VA 23225
Phone: (804) 320-4967
Fax: (804) 320-7130

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...
B. The person or identity who receives the information to which the authorization pertains, may not redisclose the information to anyone else...
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