WOMEN'S WELLNESS CENTER 645 SIERRA ROSE DR #204
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AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

INFORMATION TO BE RELEASED FROM

NAME/AGENCY

ADDRESS: FAX:

INFORMATION TO BE RELEASED TO

NAME/AGENCY

ADDRESS: FAX:

THE PURPOSE OF THIS MEDICAL RELEASE _____
(FOLLOW UP CARE/ATTORNEY/PERSONAL RECORDS)

INFORMATION TO BE RELEASED /PATIENT TO CIRCLE EACH ITEM NEEDED
THE COST OF THE COPYING OF RECORDS IS $10.00 PER PATIENT

RELEASE RECORDS FROM: START DATE: _____ FINISH DATE: _____

OFFICE NOTES	BILLING GENERATED BY THIS OFFICE
HISTORY/PHYSICAL EXAM	LABIX-RAYREPORT/EKG/CONSULTS
OPERATIVE/PATHOLOGICAL REPORT	DISCHARGE SUMMARY

THIS AUTHORIZATION IS EFFECTIVE IMMEDIATELY AND IS SUBJECT TO REVOCATION IN WRITING AT ANY TIME, EXCEPT TO THE EXTENT THAT ACTION HAS ALREADY BEEN TAKEN IN RELIANCE THEREON. OTHERWISE, THIS AUTHORIZATION EXPIRES 90 DAYS FROM THE DATE OF THE SIGNING. I FURTHER RELEASE MY ATTENDING PHYSICIANS/CLINICIANS AND/OR THE EMPLOYEES OF MARY F. WELLHONER, MD OR BRUCE S. CRAWFORD, MD FROM ANY LIABILITY ARISING FROM THE RELEASE OF INFORMATION TO/FROM THE PERSON/AGENCY DESIGNATED ABOVE.

PATIENT NAME PATIENT DATE OF BIRTH

SIGNATURE OF PATIENT DATE:

SIGNATURE OF PARENT/GUARDIAN/REPRESENTATIVE DATE:

RELATIONSHIP TO PATIENT WITNESS

CREDIT CARD INFORMATION: NAME ON CARD _____

Card Number: _____ CVV _____

Exp Date _____ Signature _____