



Women's Health Care
of Morgantown

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: _____ Date of request: _____

Address: _____

Social Security Number: _____ Phone Number: _____

I request and authorize _____

to release healthcare information to the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

This request and authorization applies to :

Healthcare information relating to the following treatment, condition, or dates:

All healthcare information

Other: _____

This information may be _____ Mailed _____ Faxed _____ Picked up

___ Continuity of Care ___ Personal Matter ___ Legal Matter

___ Insurance Claim ___ Moved ___ Other (please specify) _____

___ Yes ___ No

I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these results to anyone.

___ Yes ___ No

I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

****THIS AUTHORIZATION EXPIRES IN NINETY DAYS****