Women's Health Alliance, PA pka Mid-Carolina Ob/Gyn PC
4414 Lake Boone Trail Suite 300
Raleigh, NC 27607
919-781-5510 Phone * 919-781-5053 Fax

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

*This form **MUST** be filled out completely or the request will not be processed.*

Patient's Current Name:________________________ Chart #: ________________

Patient Maiden Name: ____________________ Date of Birth: ______________

Patient's Address: ____

FACILITY /PROVIDER BEING ASKED FOR INFORMATION:
***Attention* Your facility/provider may charge a fee for sending copies of your records to our office.**

Name: ____

Address: ____

Phone: ____________________ Fax: ________________________

I Request and authorize the above named facility to release the following health information concerning my care to:

Women's Health Alliance, PA pka Mid-Carolina Ob/Gyn, PC
4414 Lake Boone Trail Ste 300
Raleigh, NC 27607
Fax 919-781-5053

□ Send all of my records

□ Send only my records from (date) ___/___/___ to (date) ___/___/___

□ Send only the following specified records: ________________________________

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The purpose of releasing this data shall be:

□ Continued Medical Treatment □ Personal □ Second Opinion

□Complete transfer of Care

Reason for Transfer: ________________________________

□ Other: ________________________________

I understand that I may revoke this consent at any time except to the extent that action based on this consent has been taken. This consent will automatically expire after 90 days from the date on which it is signed.

Patient Signature:	**Date Signed:**