WHA, P.A. pka CAPITAL AREA OBSTETRICS & GYNECOLOGY ASSOCIATES
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Print Patient's Full Name	**Date of Birth**
Street Address	**Social Security Number**
City, State, Zip Code	**Daytime Phone Number**

RELEASE RECORDS TO: _____

Name of Company/Agency/Facility/Person

_____

Street Address including Suite #

_____

City, State, Zip Code

_____ _____

Telephone Number **Fax Number**

SEND RECORDS FROM:

Women's Health Alliance, PA pka Capital Area Ob/Gyn

1110 SE Cary Parkway, Suite 200	**4414 Lake Boone Trail, Suite 308**
Cary, NC 27511	**Raleigh, NC 27607**
Phone # (919) 467-2249 Fax # (919) 861-0495	**Phone # (919) 781-7450 Fax # (919) 861-0495**

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RELEASE INFORMATION PERTAINING TO:

___Pregnancy ___Gynecology Visits ___ Operative Notes ___Discharge Summary
___Progress Notes ___Pathology Reports ___Laboratory Reports ___Emergency Reports
___Radiology Reports ___ECG/EEG/Cardiac Cath ___Other_____

PLEASE CHECK ONE

RELEASE ALL INFORMATION:____Release information from _____ to _____
_____I DO _____ I do NOT authorize release of information related to Aids or HIV infection, Psychiatric care and/ or psychological assessment, and treatment for alcohol and/or drug abuse.

PURPOSE OF DISCLOSURE: ___Insurance ___Legal Investigation ___Workers Comp
___Disability Determination ___Personal ___Change of Doctor ___Continuing Care

I herby authorize disclosure of health information for the above named patient. This authorization is valid for 12 months from the date of signature unless otherwise noted. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized or furnished may not condition its treatment of me on whether or not I sign the authorization.

_____ _____

SIGNATURE of individual, guardian or Personal representative of patients estate **Date**

PLEASE NOTE: THERE IS A CHARGE FOR MEDICAL RECORDS. BACTES IS THE CONTRACTOR TO PROVIDE THIS SERVICE AND WILL INVOICE YOU DIRECTLY.