Women First Health Center
an Axia Women's Health Care Center

Authorization to Release Medical Records

Patient's Name: _____ DOB: _____

Patient's Address: _____

I, or my authorized representative, request that health information regarding my care and treatment be released as indicated below. I understand that:

1. My records may include information relating to alcohol and drug treatment, mental health treatment, and confidential HIV/AIDS and other sexually transmitted infection information unless excluded in section 7.
2. I have the right to revoke this authorization at any time in writing, unless action has already been taken on this consent.

3. Release To (name and address of provider):

_____

_____ Fax:( ) Phone:( )

4. Release From (name and address of provider):

_____ Fax:( ) Phone:( )

5. Purpose for the Release of Records:

6. The information below may be disclosed from: _____ (Insert Start Date) until _____ (Insert Stop Date)

☑ All health information, except as follows (if checked and initialed):

Indicate the specific information NOT to be released and initial below	Additional explanation/comments on information to be WITHHELD, if any	Initials
☐ Records from alcohol/drug treatment programs		
☐ Clinical records from mental health programs		
☐ HIV/AIDS - related information		
☐ STI - related information		

7. If not the patient, name of person signing form:

8. Relationship to the patient:

_____ _____
Signature of Patient or Representative Date

Witness Statement/Signature: I have witnessed the execution of this authorization.

_____ _____ _____
Witnesses' Name and Title Signature Date