# Women's Health For Life, Inc.

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**AUTHORIZATION FOR RELEASE AND EXCHANGE OF INFORMATION**

**FROM: Women's Health for Life, Inc.**
**Kindig ( ) Niesen ( ) Coates ( )**
**L. Brown, CNP ( ) Cindy Trent, CNP ( )**
**K. Stedke, PA-C ( )**

**To:** _____

***This information may include but is not limited to the following please check the lines you would like released:***

Medical Summary Sheet ___ Office Notes/Progress Notes___ Lab and Radiology Results___
Obstetrics Records____ Operative Notes____ Pathology Results___ Surgical Photos_____ Ultrasound____
Pap Smears___ Mammograms___ (from the past 5 years) ___Immunization or Shot Records_____
I consent to HIV, Physical abuse or Mental Health or Alcohol and Drug Records be released: Y___ or N____
Additional information requested to be released:_____

**Please note: A fee may be charged for requesting entire chart. You will be notified before records copied.**
Date of Request:_____ Patient Name:_____ DOB:_____

Name used when treatment occurred:_____

Social Security Number: _____ Minor patient: ( ) Yes ( ) NO

Dates (if known) of requested information:_____ or ( ) All treatment dates

Reason for Request: ( ) work ( ) Insurance ( ) second Opinion ( ) Transfer of care ( ) Personal
( ) Other- Please describe:_____
I hereby authorize the entity named above to release and/or exchange the above identifying information from my medical records. This release will remain in effect for six months from the date of my signature below unless I revoke this request in writing at any time. This revocation will not apply if the records have already been released to the party listed above. I understand that the office of Women's Health for Life, Inc. will not re-disclose any information contained in this authorization at any point and time with the exception of continuity of care for a condition being co-managed or referrals made from our office.

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent or Legal Guardian if Minor Patient Date

Request records to be sent:
( ) U.S. Mail ( ) Fax ( ) Electronic_____
Released to Physician ( ) or Patient ( )
If we are unable to provide an electronic copy of your medical records a hard copy will be released to you instead via U.S. Mail unless fax is checked above.
**Office Use only**: Records sent Date:_____ ( ) mailed ( ) fax ( ) electronic ( )# of pages
Sent by:_____ Approved by:_____
Notes:_____