MEDICAL RECORDS RELEASE AUTHORIZATION

Name _____ Date _____

Phone # _____ Date of Birth _____

Address _____

_____

Feminist Women's Health Center
Leading. Educating. Advocating.

☐ I will pick up the records at the clinic. OR

☐ I authorize Feminist Women's Health Center to release information to:

_____
Name of Facility

_____
Address

_____

(_____) _____
Fax Number

☐ I authorize Feminist Women's Health Center to obtain info from:

_____
Name of Facility

_____
Address

_____

(_____) _____
Fax Number

Type of Records Requested: ☐ All Medical Records ☐ If Specific Records, please describe:

_____

This Authorization is Valid For: ☐ This Request Only
☐ One Year from this date for all records of treatment prior to this date.
☐ This request and for future medical records of any treatment until _____.
(Date)

I understand that:

- My right to healthcare treatment is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a ***written*** request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- Release of HIV-related information, mental health related care, or substance abuse diagnosis and treatment information may require additional authorization.
- There may be a charge for the requested records.

Client or Representative Signature _____ Date _____

Medical Records Released by_____ On _____
Health Educator's Signature Date

Medical Records Released: ☐YES ☐NO (If NO, Reason: ☐Needs MD sign ☐Needs Chart Review)

Feminist Women's Health Center's Cliff Valley Clinic
1924 Cliff Valley Way, Atlanta, GA 30329 / (404)728-7900 / fax: (404)728-7907