NURTURE
WOMEN'S CARE

MEDICAL RECORDS RELEASE FORM

Patient Name:_____

Date of Birth: _____

Social Security Number:_____ Phone: _____

I hereby request and consent to the release of my medical records (check one below):

_____ REQUEST my medical records FROM the following:

_____ REQUEST my medical records To the following:

Doctor/Hospital:_____

Address_____

City/Sate/Zip:_____

Phone Number: _____ Fax Number: _____

Reason for release of records: _____

CHECK ALL that apply to this record release request:

	All medical records
	Lab and Diagnostic Studies Only (or Specific date range stated below
	GYN records Only
	Obstetrical records Only
	Do NOT release theses records (list):
	OTHER

I understand that all information that I consent to be obtained/released will be protected as required under the HIPAA Privacy Regulations. I understand that I may withdraw this consent at any time by written request. I have been informed that medical records are not faxed and are mailed, unless there is an urgent need for a diagnostic test result.

Signature: _____ Date: _____

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