

Premier Women's Health

REQUEST FOR RELEASE OF MEDICAL RECORDS

TO: Premier Women's Health
301 Ohio River Blvd., Suite 301
Sewickley, PA 15143

I HEREBY AUTHORIZE THAT MY MEDICAL RECORDS BE RELEASED TO:

Please include the following information:

Reason for release:

<input type="checkbox"/> All Medical Records	<input type="checkbox"/> Insurance Change
<input type="checkbox"/> Operative Report	<input type="checkbox"/> Second Opinion
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Transferring Physician
<input type="checkbox"/> Pathology Reports	<input type="checkbox"/> Moving out of area
<input type="checkbox"/> L&D, Prenatal Records	
<input type="checkbox"/> HIV and/or mental health records	
<input type="checkbox"/> OTHER _____	

PRINT Patient's Name
#

Date of Birth

Social Security

Signature

Date

Witness