Women's Health Alliance, PA pka
Centre Ob/Gyn

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Chart#: _____

Patient's Address: _____ Date of Birth: _____

_____

FACILITY / PROVIDER BEING ASKED FOR INFORMATION:
*****ATTENTION***** *Your Facility/Provider may charge a fee for sending copies of your records to our office.*

Name: _____

Address: _____

_____

I request and authorize the above named facility to release the following health information concerning me to:

Women's Health Alliance, PA pka Centre Ob/Gyn
4414 Lake Boone Trail, Suite 205
Raleigh, NC 27607

☐ Send only my records from (Date) _____/_____/_____ to (Date) _____/_____/_____

☐ Send only the following specified records: _____

_____

This purpose of releasing this data shall be:

☐ continued medical treatment ☐ personal ☐ second opinion

☐ a complete transfer of care
Reason for Transfer: _____

☐ other: _____

I understand that I may revoke this consent at any time except to the extent that action based on this consent has been taken. This consent will automatically expire after 90 days from the date on which it is signed.

Patient Signature:	**Date Signed:**