Women's Care Consultants

Authorization for Release of Medical Information

I, _____, _____,
Name of Patient ***Date of Birth***

Hereby authorize Women's Care Consultants to release from my medical record the information checked below:

☐ Complete Medical Record
- ☐ Immunization Record
- ☐ Consultant Reports
- ☐ Lab Reports including EKG
- ☐ Other (please specify)_____
- ☐ X-Ray Reports
- ☐ Physical Forms
- ☐ Insurance Claim

Dates of Treatment: _____

UNLESS OTHERWISE PROVIDED BY LAW, RECORDS AND INFORMATION CONCERNING THE FOLLOWING TYPES OF DIAGNOSES, CARE, AND TREATMENT WILL BE RELEASED ONLY IF I INDICATE MY SPECIFIC CONSENT BY CHECKING THE APPROPRIATE BOX:

- ☐ Alcohol Abuse
- ☐ Drug and Substance Abuse
- ☐ Testing for presence of HIV-Antibodies and or Treatment of AID's
- ☐ Mental Health Notes

Purpose or Need for Disclosure: (check all that are applicable)
- ☐ Further Medical Care
- ☐ Legal Investigation
- ☐ Referral
- ☐ Disability Determination
- ☐ Workmen's Compensation
- ☐ Life Insurance
- ☐ Other (please specify)

RELEASE INFORMATION TO: _____
Name of Person and Group or Company

_____
Telephone/ Fax Number

_____
Address

_____
City, State, Zip Code

_____ _____
Signature of Patient or Legal Representative ***Date***

_____ _____
Reason Patient Cannot Sign (If Legal Representative) *Relationship to* Patient

Note: To defray copying and processing costs, a reasonable fee schedule has been developed for certain types of record transfers

Women's Care Consultants

3023 N. Ballas, Suite D120, St. Louis, MO, 63131, 314.432.3669, Fax 314.432.3118