Complete Healthcare for Women of Wellington, LLC
Gynecology

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MEDICAL RECORDS RELEASE

I, _____ hereby authorize the disclosure (release) of my Medical Record information:
(Please Print Name)

TO / FROM: ___ Colette Brown-Graham, M.D., F.A.C.O.G.
___ Daxa Patel, M.D., F.A.C.O.G.

FROM / TO: _____
_____
_____
Phone: _____
Fax: _____

The Medical Record Information to be released includes: ____ Entire Record ____ Other _____
_____

I acknowledge and agree that the term Medical Record information may include notes by the provider and other personnel, results, reports, correspondence, and payment information. I expressly authorize the use and/or disclosure of information concerning HIV testing or treatment of AIDS or AIDS-related conditions, any drug or alcohol abuse, drug related conditions, alcoholism, and/or psychiatric/psychological conditions unless specifically excluded.

Please ***exclude*** the following information, if it is part of my Medical Record Information (Check any or all you want ***excluded*** from this authorization for disclosure):

___ Chemical Dependency/Substance Abuse ___ Psychiatric/psychological conditions
___ Sexually Transmitted Diseases ___ Alcohol ___ Drugs ___ N/A

I understand that this Authorization shall remain in effect for a period of **90 days**. I further understand that I may revoke this Authorization at any time by notifying Complete Healthcare for Women in writing. However, if I choose to do so, I understand that my revocation will not affect any actions taken by Complete Healthcare for Women before receiving my revocation.

The purpose of this disclosure:

___ Transferring Care ___ Insurance/Financial Issues ___Relocation ___ Other

**For personal use: $1.00 per page up to 20 pages and .25 ever page thereafter. ** To send to another physician's office: no charge.

_____ _____ _____ _____
Signature Date of Birth Social Security # Date