All About Women Health Associates, Inc.

651 Colliers Way, Suite 201 304.723.4700
Weirton, WV, 26062 304.723.4719 (fax)

Request For Release Of Medical Records

I hereby authorize **All About Women Health Associates, Inc.**, to release records on:
Patient Name:_____ SSN:_____ DOB:_____
Address: _____ Telephone:_____

Please Mail/Fax Records to:_____
_____
Telephone:_____ Fax:_____

Reason for Request: _____

Information to be disclosed:

__ Complete Health Record (s)
__ History & Physical Examination
__ Progress Notes
__X-Ray Reports

Date of services from:_____ to:_____

__ Discharge Summary
__ Consultation Reports
__ Laboratory Tests
__ Other: _____

I understand that this will include information relating to (check if applicable):

__ Acquired Immunodeficiency Syndrome (AIDS) or infection with Human Immunodeficiency Virus (HIV)
__ Psychiatric Care
__ Treatment for Drug or Alcohol abuse

This authorization shall not be valid for greater than one year from the date of signature.

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____ _____
Date Patient Signature/ Guardian & Relationship

_____ _____
Date Witness

You have the right to revoke this authorization, except to the extent of the custodian of records has relied on it, by sending your written request to: Mary Little - 4100 Johnson Rd. Ste. 100, Steubenville, OH 43952