HealthWorks
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RELEASE OF RECORDS

I,_____
(PRINT) LAST FIRST DOB SSN#

AUTHORIZE:

_____
NAME OF PHYSICIAN OR GROUP

_____
ADDRESS SUITE

_____
CITY STATE ZIP CODE

_____
PHONE NUMBER FAX NUMBER

To release my general record information to:

_____
NAME OF PHYSICIAN OR GROUP

_____
ADDRESS SUITE

_____
CITY STATE ZIP CODE

_____
PHONE NUMBER FAX NUMBER

INFORMATION NEEDED:

[] RECENT EXAM W/ PAPSMEAR RESULTS
[] COLPOSCOPY/CRYOTHERAPY EXAM W/ RESULTS
[] RECENT MAMMOGRAM W/ RESULTS
[] OTHER:_____

_____

I UNDERSTAND THAT THE REQUESTER MAY NOT FURTHER USE OR DISCLOSE THE MEDICAL INFORMATION UNLESS ANOTHER AUTHORIZATION IS OBTAINED FROM ME OR UNLESS SUCH DISCLOSURE IS SPECIFICALLY REQUIRED OR PERMITTED BY LAW. I FURTHER UNDERSTAND THAT I MAY RECEIVE A COPY OF THIS AUTHORIZATION UPON MY REQUEST.

SIGNATURE_____ DATE_____

STAFF_____

Updated 12/28/04 SG