Axia Women's Health

Authorization to Release Medical Records

Patient's Name: DOB:

Patient's Address:

I, or my authorized representative, request that health information regarding my care and treatment be released as indicated below. I understand that:

1. My records may include information relating to alcohol and drug treatment, mental health treatment, and confidential HIV/AIDS and other sexually transmitted infection information unless excluded in section 7.
2. I have the right to revoke this authorization at any time in writing, unless action has already been taken on this consent.

3. Release To (name and address of provider):

Fax:( ) Phone:( )

4. Release From (name and address of provider):

Fax:( ) Phone:( )

5. Purpose for the Release of Records:

6. The information below may be disclosed from: _____ until _____
INSERT START DATE INSERT STOP DATE

☑ All health information, except as follows (if checked and initialed):

Indicate the specific information **NOT** to be released and initial below.	Additional explanation/comments on information to be **WITHHELD,** if any.	Initials
☐ Records from alcohol/drug treatment programs		
☐ Clinical records from mental health programs		
☐ HIV/AIDS - related information		
☐ STI - related information		
☐ Genetic testing – related information		

7. If not the patient, name of person signing form:

8. Relationship to the patient:

_____ _____
SIGNATURE OF PATIENT OR REPRESENTATIVE DATE

Witness Statement/Signature: I have witnessed the execution of this authorization.

_____ _____ _____
WITNESSES' NAME AND TITLE SIGNATURE DATE