Professional Women's HEALTHCARE P.A.

MEDICAL RECORDS REQUEST

Patient s Full Name_____
Any Other Names Patient May Be Listed As_____
Address_____
City, State, Zip_____
Date of Birth_____

I hereby request the following medical records in the possession of the provider, including, but not limited to, records, reports, tests or information concerning mental illness or developmental disabilities, psychotherapy notes, HIV/AIDS testing or treatment, communicable diseases, venereal diseases, substance abuse, abuse of an adult with a disability, sexual assault, child abuse and neglect, genetic testing and abortions (***if you wish to limit the material disclosed above in any way, please indicate exactly what you do not want released***):

Please initial:

___	Complete Medical Record	___	Emergency Reports
___	Clinic Notes	___	Lab Results
___	Operative Reports	___	Pap Smear Results
___	Pathology Reports	___	Mammogram Reports
___	Ultrasound/X-Ray Reports	___	Discharge Summaries
___	Other: _____		

For the following dates of treatment: (for example: specific date, range of dates, all dates of service)
_____

be released by Fax ____ or Mail ____

FROM:(name)	**TO**: Professional Women s Healthcare, P.A.
(address)	103 Hunt Drive
(address)	Dunn, NC 28334
(tel. #)	Tel.: (910) 897-7711
(fax #)	Fax: (910) 897-2654

The purpose of the disclosure is: ___ continued patient care ___ other:_____

***This request is valid for 6 months from date of the above signature. I understand that I may change my mind and revoke this Medical Records Request in writing at any time by notifying the Privacy Officer. I understand that changing my mind will not affect my treatment. The revocation will not apply to the extent that Professional Women s Healthcare has already taken action where it relied on my permission. I understand that I have the right to inspect or copy any information used/disclosed under this authorization. I understand that I may refuse to sign this Medical Records Request, and if I do refuse, my ability to obtain treatment will not be affected unless the only purpose of treatment is to create health information for the disclosure listed above. I have read and understand this Medical Records Request and had a chance to ask questions about the disclosure of health information. I authorize Professional Women s Healthcare, P.A. to use my health information in the manner described above.

X_____
Signature of Patient Date