Women's Care, Inc.
of Mansfield

Medical Records Request/Release

Patient Name: _____ Date of Birth_____ SS#: _____
Address: _____ Phone: _____

□ **Request from:** **or** □ **Release to:** **Women's Care Inc.** **500 South Trimble Road** **Mansfield, OH 44906** **Phone: 419-756-6000** **Fax: 419-756-7885**	□ **Request from:** □ **Release to:** **Name: _____** **Address: _____** **City:_____ State: _____ Zip: _____** **Phone: _____ Fax: _____**

NOTE: There will be a charge for patients requesting records to be released to themselves.

Release the following medical records (limit to the last two years):

_____ X-ray & Diagnostic Reports
_____ Last Office Notes
_____ Prenatal/Delivery Records
_____ Operative/Procedure Notes & Pathology
_____ Ultrasounds
_____ Lab Reports

The reason for release is: **Fee may apply*
□ Continuation of Care □ Litigation* □ Transfer of Care □ Insurance Application* □ Out of Town Move
□ Other _____

This authorization will expire one year from the date of signature below or on _____.
I understand that I have the right to revoke this authorization at any time by sending a written notice to the health care facility/provider noted above. Revocation of this authorization will not apply to records that have already been released. I understand that I must revoke this authorization in writing to the above provider.

I understand the information in my record may include information relating to sexually transmitted diseases, Acquired Immunodeficiency Syndrome (AIDS), or infection with Human Immunodeficiency (HIV). It may also include information about behavioral or mental health services treatment for drug or alcohol abuse.

I understand that any disclosure of information carries with it the potential for re-disclosure and that the information may not be protected by federal confidentiality rules.

I understand that authorizing this disclosure is voluntary. I can refuse to sign and I need not sign to ensure treatment. However, if this authorization is needed for participation in a study, my enrollment may be denied.

Patient/Legal Guardian Signature: _____ Date: _____
Relationship to patient: _____