

# Zweibach Women's Health

## MEDICAL RECORD RELEASE AUTHORIZATION

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

I hereby authorize Zweibach Women's Health:

**Release Medical Records To:**

**Obtain Medical Records From:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Description of Information to release:

- All Medical Information and Reports
- Operative Report(s)
- X-Ray/Ultrasound Reports
- Prenatal Records
- Lab Results (including HIV, hepatitis, and all STD results)

### Purpose of Disclosure:

Insurance       Changing Physicians       Consultation / 2<sup>nd</sup> Opinion       Moving

Other \_\_\_\_\_

I understand by signing this form, that these medical records may or may not contain information pertaining to psychiatric counseling or testing, alcohol or drug abuse counseling or testing, and/or HIV testing. I do expressly and voluntarily authorize the disclosure of the said medical records to the person(s) and/or entity (ies) as stated above. This authorization/consent will remain in effect for a period of one (1) year from the date stated below, unless revoked in writing by the person to which it pertains (or her parent, legal guardian or legally authorized agent), to the Medical Records Department. These medical records are being disclosed under the provisions of Health Insurance Portability and Accountability Act of 1996 (HIPAA).

\_\_\_\_\_  
Patient, Parent, Legal Guardian of  
Legally Authorized Agent

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_  
Witness