AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

RECORDS TO:

Name _____

Address _____

Phone_____ Fax_____

City _____ State_____Zip_____

RECORDS FROM:

Westside Women's Care
3555 Lutheran Pkwy., Suite 210
Wheat Ridge, CO 80033

Phone: 303.467.2800
Fax: 303.467.2861

I authorize the release of records, including those that may contain confidential HIV/AIDS related information, confidential communicable disease-related information and information relating to mental health and/or alcohol/drug use. Please release the following records:

_____Prenatal/Obstetrical Records

_____Lab Reports

_____Other (specify below)

_____Operative/Pathology Reports

_____Gynecological Records

_____Records Generated at WWC
(Last three years of pertinent medical records)

_____

_____

PRINT Patient's Name_____

Patient's Date of Birth _____ Patient's Social Security #_____

Are you transferring from this practice?_____

This consent will expire automatially six months from the date on which it is signed.

Signature of Patient/Representative _____ Date_____