Westside Women's Care

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Records To:

Name: _____

Address: _____ Phone: _____

City: _____ State: _____ ZIP: _____ FAX: _____

Records From: *Westside Women's Care* Phone: (303) 424-6466

7950 Kipling St. Ste.201 FAX: (303) 420-8944

Arvada, CO. 80005

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 SSN:** _____

Are you Transferring from this practice?_____

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

Signature of Patient: _____ **Date:** _____

PLEASE DO NOT SEND RECORDS ON CD

If records are released directly to another physician, there will be no charge. If records are requested for a personal or insurance request, a fee will be required.

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