

Women's Health Consultants, P.A.

**Authorization for Disclosure of Health Information/
Patient Request for Access to Patient Health Information**

Patient Information

Patient Name (Last, First, Middle)		Account/Chart Number	
Street Address	City	State	Zip
Date of Birth	Social Security # (optional)	Day Phone	Evening Phone

Information Released From

Information Released To/Exchanged With

Name	Name
Facility	Facility
Street Address	Street Address
City State Zip	City State Zip
Phone Fax	Phone Fax

Please Indicate the Information To Be Disclosed

- History & Physical
- Laboratory Results
- Pathology
- Radiology
- Surgical Records
- All Records
- Other (Specify): _____

This Information Is To Be Released for the Purpose Of

- Patient Access
- Insurance Application
- Continuing Care
- Litigation
- Transfer of Care
- Other (Specify): _____

Note: A fee may be charged in accordance with MN Statute 144.335 and Federal Rule 164.524.

I understand that I may revoke this authorization at any time with written notification, but that the revocation will not have any effect on the information released prior to notification of revocation.

Patient/Legal Representative Signature Date Authority to act on behalf of patient (attach document) Information released by Date