# Authorization to Release Medical Records

PLEASE GIVE THIS TO YOUR PREVIOUS DOCTOR

This letter will authorize you to provide a copy, summary, or narrative of my medical records (as indicated by the check mark(s) below) or to otherwise release confidential information. At this time I am requesting the following:

__________ Complete record
__________ Records of care from ____________________ to _______________ only
__________ Records of care concerning the following condition(s)
______________________________________________________________________
__________ Other. Specify:
_____________________________________________________
__________ Confer with other person orally about information in my medical record

To be sent to: Athens Women's Health Center
115 Medical Circle Suite 103
Athens, TX 75751
Fax: 903-677-8454

**HIV/AIDS**. I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS, or infection with any other causative agent of AIDS, with the rest of my medical records.

Initial ______Date ________________

The reasons or purposes for this release of information are: Transfer of my records for continued treatment.

I understand that you will provide this information within 15 business days from receipt of request, and you may charge a fee for preparing and furnishing this information (although this fee will be waived when records are transferred directly between physicians).

Signed:____________________________________ Date: ___________
(Patient or person legally authorized to consent on patient's behalf)

Printed Name: ____________________________________________
(Patient or person legally authorized to consent on patient's behalf)

Patient's Date of Birth: ____________ Social Security Number: _________________