

114 Nationwide Drive
Lynchburg, VA 24502



(434) 239-7890
Fax (434) 237-9222

For WHSCV TO RELEASE RECORDS

I understand that this authorization may be revoked at any time in writing. I hereby authorize the release of the following protected health information:

1. Please Release Records From:

Women's Health Services of Central Virginia

Facility/Employer

114 Nationwide Drive, Lynchburg VA 24502

Ph: (434) 239-7890 Fax (434) 237-9222

2. To Be Sent To:

Name of Physician/Health Care

Street Address

City/State/Zip Code

Phone Number/ Fax Number

3. INFORMATION TO BE RELEASED:

Please be specific regarding types of information, i.e. , diagnosis treatment, lab results, billing information may be released.

Clinic/Progress Notes

Laboratory Reports

Pap/Cytology/Pathology

Bone Density Reports

Mammogram Reports

OB Records

ALL RECORDS

Other _____

4. RECORDS FROM THE TIME PERIOD: _____ to _____.

Specify Dates

5. PURPOSE OR NEED FOR RECORDS:

Further Medical Treatment

Other (specify) _____

6. PATIENT IDENTIFICATION

Patient Name:

SSN:

DOB:

Patient Address:

PHONE: (H) _____ (W) _____

This authorization is in force for 30 days following the date signed.

Signature of Patient

{DATESTAMP()}

Date

This Protected Health Information, once released from Women's Health Services of Central Virginia's custodial care per the instructions specified on this authorization, may be reproduced or released by the receiving entity. This subsequent reproduction/release is beyond Women's Health Services of Central Virginia's control and authority.