AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, the undersigned, hereby authorize _____
_____
_____
_____

To release the following information from my medical records: The authorization includes release of information concerning HIV testing or treatment of AIDS, AIDS related conditions, drug or alcohol abuse, and drug related conditions, and/or psychiatric/ psychological conditions. The following information may be released or reviewed:

___ Entire Medical Chart- including previously released records

___ Only the following items:
_____
_____
_____

Please FAX above records to: **513-985-9391 (We prefer records to be faxed)**

OR MAIL TO:

Associates in Women's Health
8231 Cornell Road
Suite 320
Cincinnati, Ohio 45249
513-794-1500

I hereby state that I have read and fully understand the above statements as they apply to me. I hereby consent to the disclosure of the treatment records for the purpose and extent stated above. I release the above named institute of any claim pertaining to the release and use of medical data of the contents thereof.

Patient Name: _____ Birth Date ___/___/_____
(Please Print)
Street Address: _____

City, State and Zip: _____

Signature: _____ Date: ___/___/_____
(Patient, parent or legal guardian)
Telephone: _____ Witness: _____