WISE WOMAN OB/GYN

Caring for women of all generations

RELEASE OF INFORMATION FORM:

TO: Wise Woman OB/GYN ----- provider releasing records.

I _____(name of patient) request that the records of my medical care be released to: (Enter Information of provider to release to)

_____

_____

Records to be released:

HIV Testing
Initial Here:_____

___ All
___Ob record
___Surgical records and pathology
___Radiology
___Papsmear and labs
___Office Visits
___Other_____

This authorization shall be in force and effect for 90 days from the date of signing. I understand that I have the right to revoke this authorization in writing at anytime. I understand that there is a potential for information used or disclosed pursuant to this authorization to be subject to redisclosure by the recipient and no longer protected by federal or state law.

Thank you,

Pt signature: _____

DOB_____

Date_____

Nanci Lynn Hawkins, MD, FACOG · Joyce Wilder, MSN, CNM, WHNP · Jody Hill, MSN, CNM
172 Clinton Street, Watertown, NY 13601
Phone: 315-782-6262 Fax: 315-782-5181 www.WomensHealth.to