WOMEN'S HEALTH CARE GROUP OF PA
Women's Healthcare Division

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

(Note: This form must be fully completed and payment of fee required before records are released. Incomplete or incorrect information will delay release of records.)

Obstetrics
Gynecology
Infertility

Charles V. Touey, M.D., F.A.C.O.G.

Rosalie Lisa, C.R.N.P.

Christine Campbell, C.R.N.P.

_____ _____
Patient's Full Name (Please Print) Date of Birth

_____ _____
Previous Name Social Security #

Address: _____
Street City State Zip

_____ _____
Daytime Phone # Cell Phone #

RELEASE RECORDS FROM: **RELEASE RECORDS TO:**

_____ _____

_____ _____

_____ _____

_____ _____
Phone # Fax# Phone # Fax#

MEDICAL INFORMATION REQUESTED: Dates of Services: From _____ To_____

_____Laboratory Reports _____X-Ray Reports _____Pap Smear _____Last _____Years

_____Other/All Healthcare Information (Please note records of other Doctor's/ Hospitals will not be released)

_____

PLEASE INCLUDE THE FOLLOWING HEIGHTENED CONFIDENTIAL TREATMENT INFORMATION:

_____HIV/AIDS _____Mental Health _____Alcohol Abuse _____Drug Abuse

_____Sexually Transmitted Diseases (STDs)

REASON FOR RELEASE: ___I have been referred to another doctor ___I want/need a second opinion ___I am changing doctor (provider) ___Dissatisfaction with care ___My insurance changed ___I am moving (New Address)_____

_____

_____pecify

Please Specify Appointment Date: _____ or Pick-up Date:_____

********PLEASE ALLOW 5-7 BUSINESS DAYS********

_____ _____
Signature of Patient or Patient's Legal Representative Date

_____ _____
Witness Date

Payment received _____ cc____ cash____