Request for & Authorization to Release Health Information

Please Fax (888-974-8709) or email (office@metrowomensva.com) this request to MWC.

Metro WOMEN'S CARE

CLIENT INFORMATION — CLIENT ID #:

Name:

Date of Birth: Phone:

Address:

City: State: Zip:

Email:

I authorize and request Metro Women's Care to release or disclose my health information to the following:

❑ **Physician/Health Care Entity**:
Phone: **Fax:**
Address: City: State: Zip:

❑ Family Member: ❑ Other:
Phone number: Phone number:

HEALTH INFORMATION TO BE RELEASED OR DISCLOSED

- ❑ Ultrasound Examination Report
- ❑ Verification of Positive Pregnancy Test
- ❑ Health History
- ❑ Other Records:

PURPOSE

- ❑ Medical Follow up
- ❑ Personal Use
- ❑ Insurance
- ❑ Other:

RECORD DISPOSITION

❑ Fax to the number listed above ❑ Please mail the records ❑ I will pick up my records in person
❑ Email to the address above (I acknowledge that email may be unencrypted but consent to have my records emailed anyway.)

ACKNOWLEDGEMENTS

As the person signing this authorization, I understand that I am giving my permission to Metro Women's Care for disclosure of confidential health records.

I understand that signing this authorization is voluntary and that care will still be provided to me without signing this form.

I understand that written notification is necessary to cancel this authorization. I also understand that my cancellation will not apply to disclosures already made in reference to this authorization.

A copy of this authorization and a notation concerning the persons or agencies to whom disclosure was made shall be included with my original health records. I understand that health information disclosed under this authorization might be re-disclosed by a recipient and may, as a result of such disclosure, no longer be protected to the same extent as such health information was protected by law while solely in the possession of Metro Women's Care.

Client or Authorized Representative (Signature) — Date/Time (Authorization Expires 90 Days from Date)

Client or Authorized Representative (Print Name) — Relationship to Client

Label