450 Mamaroneck Avenue, Suite 414, Harrison, NY 10528 t: 914.421.1515 f: 914.421.1501 email: medicalrecords@fullcirclewh.com

MEDICAL RECORDS RELEASE FORM

Patient Name:			
Patient Address:			
Home #:	Work #:	Cell	#:
Birth Date:	Social Secu	rity No.:	
Please send a copy of my m	edical records:		
FROM: Provider's Name:			TO: Medical Records Full Circle Women's Health 450 Mamaroneck Avenue Suite 414 Harrison, NY 10528
Practice Name:			
Practice Address:			
City, State, Zip:			
Fax #:		Tel #:	
Please specify which medica	ıl records you want rele	ased and/or date	es of service:
Annual exam and pap	smear	Surgical recor	ds
Pregnancy/Prenatal		Sonograms and Labs - copies of actual lab reports	
All medical records		Other	
Disclosure of information re	egarding drug and/or alo ding testing or treatmer	cohol abuse and nt of HIV/AIDS a	d Federal confidentiality regulations treatment, confirmed sexually and diagnosis of mental illness or
This consent can be revoked previously revoked, this cor	•		een taken in reliance on it. If not
I further authorize and requ	est that you accept a fa	xed copy of this	authorization as the original.
Signature	Date	Witness	 Date