

Women's Health Specialist of Frederick
75 Thomas Johnson Dr. Ste. J
Frederick, MD 21702
Phone: 301-620-0010
Fax: 301-682-3977

Authorization for Release of Patient Identifiable Health Information

I, _____, authorize Women's Health Specialists of Frederick, LLC to
_____ release or _____ obtain medical records from:

(Physician, Hospital, Attorney, Insurance Company, self, etc)

(Address, City, State, Zip code)

The following health information from the medical records of

Patient Name

Date of Birth

Phone Number

- Complete Medical Records (up to 2 years)
- Lab results
- Imaging
- Other _____

**If records release to patient,
fees need to be paid prior to
or at pickup. Cost is .76
cents per page.

I understand that the information in my health records may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral and/or mental health services and treatment for alcohol and/or drug abuse.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Office Manager of Women's Health Specialists of Frederick, LLC. I understand that the revocation will not apply to the information that was already released.

Unless otherwise specified, this authorization will remain valid for six months from the date signed. I voluntarily sign this authorization, and I understand that my healthcare will not be affected if I do not sign this form.

Signature of patient or legal representative

Date

