Aradia Women's Health Center

Medical Records Release Form

In order to ensure that your medical records are held in the utmost confidentiality please be as explicit as possible as to where you want them sent.

Name:

_____

Address:

_____

(Street) (City) (State) (Zip)

Home Phone: _____

Work Phone: _____

Birthdate: _____/_____/_____

Please transfer my medical records:

From: _____ **To:**

_____

_____

_____

Please specify which medical records you want released:

- ☐ Annual exam and pap smear
- ☐ Birth control related services
- ☐ Abortion care
- ☐ All medical records
- ☐ Other _____

I understand that my medical records are protected under State and Federal confidentiality regulations. Disclosure of information regarding drug and/or alcohol abuse and treatment, confirmed sexually transmitted infections, including testing or treatment for HIV/AIDS, and diagnosis of mental illness or psychiatric care cannot be released without my written consent.

Please initial the box below if you **DO NOT** want any of the following records released. All applicable records will be released if nothing is marked.

- ☐ Drug and/or alcohol abuse, diagnosis or treatment
- ☐ HIV/AIDS testing and/or treatment
- ☐ Psychiatric care and/or mental illness
- ☐ Confirmed STI test results and/or treatment

This consent can be revoked by me at any time unless action has been taken in reliance on it. If not previously revoked, this consent will terminate in 90 days.

_____
(Signature)

_____
(Witness)

_____
(Interpreter, if necessary)

_____

(Date)