

# Augusta Health Care for Women

39 Beam Lane Fishersville, VA 22939

Phone (540) 213-7750

fax (540) 213-7755

## Authorization for Release of Medical Information

\_\_\_\_\_  
(Print patients full name)

\_\_\_\_\_  
Birth date (Mo/Day/Yr)

\_\_\_\_\_  
(Street Address)

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
(City, State, Zip code)

\_\_\_\_\_  
Phone

I do hereby authorize \_\_\_\_\_

(Name of Facility)

To send the following:

Progress Notes

Lab Reports

Sexually Transmitted Diseases

Discharge Summary

Radiology Reports

Entire Record

History & Physical

Pathology Reports

Other \_\_\_\_\_

Operative Notes

Prenatal Records

(Please specify) \_\_\_\_\_

Immunization Records

**Dates of:** \_\_\_\_\_

I understand that my health information may include general information related to my psychiatric health, drug/alcohol abuse, communicable diseases, abortion, or other information I may consider sensitive.

**Information Release To:** **Augusta Health Care for Women**

**Attn: Medical Records**

**39 Beam Lane**

**Fishersville, VA 22939**

**Please circle which Provider:** Daniel B. McMillan, MD      Kelly E Jensen, MD      Molly M. Gilham, MD  
Mary E Kwiecinski, CNM      Debbie, Meslar-Little CNM      Kari Somer, CNM  
April Reagan, CNM

**Purpose of Disclosure:**

Referral to Specialist

Insurance

Personal

Disability Forms

Continuing Care

Attorney Request

FMLA

Workers Comp

Other(specify) \_\_\_\_\_

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification and that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I need not sign this form to ensure healthcare treatment. Upon request, I will be given a copy of this authorization.

\_\_\_\_\_  
Signature of individual or guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date