



Southern Indiana
Women Physicians for
P.C.

RECORDS RELEASE AUTHORIZATION

Release records from:

Physician or Hospital

Address/Telephone Number

I hereby request and authorize you to release:

Only the following tests or records: _____

My complete medical record - I understand that I am not required to release genetic testing or counseling results.

Release the above information to:

Physician or Hospital

Address/Telephone Number

This release is good for sixty days unless I revoke it by writing before such time.

Name: _____ Maiden Name: _____

Date of Birth: _____

Address: _____

Signature: _____ Date ____/____/____

Witness: _____

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Relationship of Witness to patient: _____