South Lake Women's Healthcare, PLLC
Authorization to Release Medical Records

Name of Patient: _____ Date of Birth:_____

I, the undersigned, authorize the release of, or request access to the information specified below from the medical record(s) of the above name patient.

PATIENT INFORMATION IS NEEDED FOR:

Continuing Medical Care	School	Other: _____
Personal Use	Legal Purposes	

INFORMATION TO BE RELEASED OR ACCESSED:

Complete Record	Emergency Room Record	Lab/Path Reports
History & Physical	Operative Reports	X-Ray Reports/Images
Consultation Report	Discharge Summary	Other: _____

The above information may be released
TO:

South Lake Women's Healthcare, PLLC
19453 West Catawba Ave, Suite A,
Cornelius, NC 28031

Phone: 704-896-9912
Fax: 704-896-9913

FROM:

_____ Phone:_____

_____ Fax:_____

_____

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.

The authorization will expire twelve (12) months from the date of my signature, unless I revoke the authorization prior to that time.

Sign: _____ Date: _____
Patient or Legally Authorized Representative

Print: _____ _____
Patient or Legally Authorized Representative — Relationship to Patient