
**418 Chatham Square Office Park, Fredericksburg, VA 22405**
**Phone: 540-374-7020 Fax: 540-374-7030**

**Informed Authorization and Consent for the release of Medical Records**

I hereby authorize Elite Gynecology and Wellness to:

( ) **RELEASE** ( ) **OBTAIN** the medical records of: _____

whose date of birth is: _____and date of treatment was _____.

( ) **RELEASE TO:**

_____

_____

_____

( ) **OBTAIN FROM:**

_____

_____

_____

**for the purpose of:** _____

Please indicate what specifically is to be released:

( ) Entire Medical Record ( ) Mammography ( ) Laboratory Tests

( ) Discharge Summary ( ) Operative Reports ( ) Pathology

( ) Other: _____

As the person signing this authorization, I understand that I am giving my permission to Elite Women's Health Inc for disclosure of confidential health records. I understand that Elite Women's Health Inc may not condition treatment or payment on my willingness to sign this authorization unless the specific circumstances under which such conditioning is permitted by law are applicable and are set forth in this authorization. I also understand that I have the right to revoke this authorization at any time, but that my revocation is not effective until delivered in writing to the person who is in possession of my health records and is not effective as to health records already disclosed under this authorization. A copy of this authorization and a notation concerning the persons or agencies to whom disclosure was made shall be included with my original health records. I understand that health information disclosed under this authorization might be redisclosed by a recipient and may, as a result of such disclosure, no longer be protected to the same extent as such health information was protected by law while solely in the possession of Elite Women's Health Inc.

_____ _____

***Patient Signature*** ***Date Signed***