MERCY CARE
FOR WOMEN'S HEALTH • OB-GYN

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I hereby authorize Mercy Care for Women's Health to release my Medical Records which may include STD, HIV, AIDS, behavioral and mental health

PATIENT NAME : _____

Date of Birth : _____

Address : _____

_____

Celphone Number : _____

Email address : _____

TERMS AND CONDITIONS :

1) **Please send us a check of $18** (includes flash drive, processing and certified mailing fee) **payable to Cynthia P. Mangubat, MD.**
2) **Please mail this form together with your check payment to:**

Cynthia P. Mangubat, MD
Mercy Care for Women's Health
P. O. Box 248
Camden DE 19934

3) Medical record will not be processed and released without the check payment.
4) Please allow us to process your request within average of 30 days.
5) Medical records are retained 7 years after the last date of service.
6) Mercy Care for Women's Health reserves the right to process your medical record in any form or mail your medical records in any manner.
7) This form is valid until further notice and this request is valid for 30 days from the date signed.

PATIENT SIGNATURE : _____ **DATE** : _____