



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 \$20 (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 292
Pontiac, IL 61764

- 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 : _____