MERCY CARE
FOR WOMEN'S HEALTH • OB-GYN

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I hereby authorize Mercy Care for Women's Health to release the following Medical Records:

- ☐ Laboratory Result
- ☐ Operative Report
- ☐ Office/Annual Visit
- ☐ Prenatal Records
- ☐ Pap Smear
- ☐ History & Physical
- ☐ Imaging Studies
- ☐ Others _____
- ☐ Entire Medical Record

Note: Medical Record may include HIV, STD, substance and mental abuse.

Purpose:

- ☐ Transfer of Care
- ☐ Medical Treatment/Management
- ☐ Personal Use/Employment
- ☐ Insurance
- ☐ Legal
- ☐ Others_____

Please send by fax or mail the requested information to:

PRACTICE/Doctor's Name: _____

Address : _____

Phone / Fax Number : _____

This request is valid for 30 days from the date below.

_____ _____

Name **Address**

_____ _____

DOB **Signature / Date**