MERCY CARE
FOR WOMEN'S HEALTH • OB-GYN

AUTHORIZATION TO RELEASE MEDICAL RECORDS

PRACTICE/Doctor's Name: _____

Address : _____

Phone / Fax Number : _____

May I request the following Health Information:

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

Purpose:

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

Please send by fax or mail the requested information to:

Cynthia P. Mangubat, MD FACOG
Mercy Care for Women's Health, LLC
819 S. Governors Ave., Dover DE 19904
Fax: 302-736-6951

This request is being made to provide Medical care and is valid for 30 days from the date below.

_____ Name

_____ Address

_____ DOB

_____ Signature / Date