Christa S. Littrell, D.O.
Jeanine M. Loncar, M.D.
Eleanor L. Murray, M.D.
David L. Rushing, M.D.

Clinic for Women

Karen Leigh Samples, M.D.
Shanna V.N. Shumaker, M.D.
Victoria B. Perkins, M.D.
John David Wheeler, M.D.

OBSTETRICS AND GYNECOLOGY
FEMALE INFERTILITY
FELLOWS OF THE AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

Authorization for Release / Request of Protected Health Information

Patient's Name: _____ Date of Birth: _____

Address: _____

City/State/Zip Code: _____

SS#: _____ Patient's Phone #: ( ) _____

Date of Request: _____ Date Needed: _____

☐ I authorize The Clinic for Women to release information to:

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone # / Fax # (Include Area Code)

OR

☐ I authorize The Clinic for Women to obtain information from:

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone # / Fax # (Include Area Code)

Purpose For This Request: (Check one) ☐ Healthcare ☐ Insurance Coverage ☐ Personal ☐ Other

Type of Records Requested: (Check One)

☐ Specific Information (Select one or more, as applicable)

- ☐ Operative report
- ☐ Laboratory Test Results
- ☐ Office Notes
- ☐ Other: _____
- ☐ History & Physical
- ☐ X-Ray Reports
- ☐ DEXA Results
- ☐ Consult
- ☐ Discharge Summary
- ☐ MMG

☐ All medical records related to a specific illness or injury

_____
Specify Illness / Injury — Date(s) of Treatment

I understand that:

- My right to healthcare treatment is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a *written* request to the address provided at the top of this form, expect where a disclosure has already been made in reliance on my prior authorization
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be re-disclosed.
- Release of HIV-related information, mental health related care, or substance abuse diagnosis and treatment information requires additional authorization.
- Expiration Date

NOTE: Medical Records are faxed in cases of medical necessity only.

Signature of Patient: _____ Date: _____

Witness: _____

Date Mailed: _____

910 Adams Street, Suite 300
Huntsville, Alabama 35801
Telephone: (256) 533-7420
Facsimile: (256) 536-4109