

TotalCare for Women
A Division of Mid-Atlantic Women's Care, P.L.C.
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Chesapeake, VA 23320 Virginia Beach, VA 23455
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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

_____ I have been advised and understand that there may be a fee involved in the copying of my record (s).
(Initials) (You may be contacted by medical records prior to copying records with fees if any apply)
All FMLA/Insurance/Disability and any other forms requiring completion will have a flat rate charge of
\$15 per form(s) (not per page). Any updates will be an additional \$6 fee.

_____ I have been advised and understand that it may take between 7 to 14 business days to process this request.
(Initials)

Patients Full Name (please print)	Birth Date (Month/Day/Year)
Street Address	Social Security Number
City, State, Zip Code	Phone (Home and Alternate number)

At my request, I _____, do hereby authorize TotalCare For Women to release:

_____ Pathology	_____ Laboratory Results
_____ History & Physical	_____ Radiology Reports
_____ Progress Notes	_____ Entire Record
_____ ECC/EEG/Cardio Cath	_____ Other (specify) _____

Purpose of Disclosure:

_____ Referral to Specialist	_____ Insurance	_____ Workers Comp
_____ Legal Investigation	_____ Disability Determination	_____ Personal
_____ Moving		
Other (specify) _____		

Information Release To:

_____ Name (Example Physician, hospital, agency, etc.)
_____ Street Address
_____ City, State, Zip Code
_____ Phone and Fax

Information Release From:

_____ Name (Example Physician, hospital, agency, etc.)
_____ Street Address
_____ City, State, Zip Code
_____ Phone and Fax

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that the information used or disclosed may be subject to re-disclosure by the persons or facility receiving it, and would then no longer be protected by the federal regulation. I understand that I may cancel this request with written notification of cancellation.

Signature of individual, Guardian or Power of Attorney	Date
Signature of person witnessing this request	Date
Request Completed By	Date