Rappahannock Women's Health Center, P.C.
1071 Care Way, Suite 101 Fredericksburg, VA 22401
Tel: 540-374-3100 Fax: 540-374-3102

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #:_____

I request and authorize Rappahannock Women's Health Center to release healthcare information to the following parties:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

This request pertains to the following information:

□ Health information relating to the following treatment, condition, or dates: _____

_____

□ All healthcare information

□ Other: _____

□ Yes □ No I authorize the release of STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that must give specific written permission before disclosure of these test results to anyone

□ Yes □ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to The person(s) listed above.

I understand that due to HIPPA regulations that this can only be done with my consent. This consent will be in effect until the following date: _____ Unless otherwise retracted in writing.

Patient Signature: _____ Date Signed: _____