



Authorization to Release Medical Records

Patient Name: _____ Date of Birth: _____
 Maiden Name: _____ Other Names Used: _____
 Address: _____ Phone: _____
 _____ Soc. Sec. #: _____
 Dates of Service: _____ To _____
Date Date

OBSTETRICS GYNECOLOGY INFERTILITY

Robert W. Davis, M.D.
 John M. Werdel, M.D.
 Timothy A. West, M.D.
 B. Kerry Lowder, M.D.
 Bryan F. Hodges, M.D.
 Necole Javernick-Hodges, M.D.
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 Anthony J. Schirer, C.M.P.E.
 Practice Administrator

Associates Emeritus
 Harold E. Dedman, M.D.
 Mary Lou Holdren, M.D.
 Verne J. Reynolds, M.D.
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SATELLITE OFFICE
 ST. LUKE'S MERIDIAN MEDICAL CENTER
 520 S. EAGLE ROAD
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 MERIDIAN, IDAHO 83642

I authorize that my medical records be released:

From: Name: _____
 Address: _____
 City, Zip: _____
 Fax #: _____
 To: Name: _____
 Address: _____
 City, Zip: _____
 Fax #: _____

Purpose for Medical Records Release: _____

Copies to be Released:

- | | |
|---|---|
| <input type="checkbox"/> All Records | <input type="checkbox"/> Lab Reports |
| <input type="checkbox"/> Operative Report | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Discharge Summary | _____ |

*I understand that, unless otherwise specified by me, the records to be released by The Woman's Clinic will include records created by The Woman's Clinic as well as medical records created by other health care providers whose records are a part of The Woman's Clinic chart.

This consent will expire on _____ or 120 days after the date it is signed, or sooner at my written request.

SPECIFIC AUTHORIZATION

Substance Abuse Mental Health Treatment Information HIV (AIDS) Test Results
 I acknowledge that data to be released MAY INCLUDE material that is protected by Federal Law to ANY or ALL of the above.

My signature below authorizes release of all such information.

This facility, its employees and officers, and attending physicians are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

Signatures

Patient/Legal Guardian: _____ Date: _____
 If not patient, relationship to patient: _____ Date: _____
 Witness: _____ Date: _____