# VALLEY WOMEN'S HEALTH CARE

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## AUTHORIZATION TO RELEASE MEDICAL RECORDS

**PATIENT'S NAME (printed):** _____

**DATE OF BIRTH:** _____

**ADDRESS:** _____

**CITY** _____ **STATE** _____ **ZIP** _____

Susan Lemagie, M.D., I hereby authorize you to release my medical records to the following:

_____

_____

_____

**For the purpose of:**

☐ Further medical treatment
☐ Insurance claims
☐ Worker's compensation
☐ Legal request
☐ Other, please specify: _____

**Records to be released are:**

| | | |
|---|---|---|
| ☐ Office Notes | ☐ Laboratory studies | ☐ Radiology reports/X-rays |
| ☐ Pathlogy reports | ☐ History & Physical reports | ☐ Discharge summary |
| ☐ Operative reports | ☐ Alcohol/drug information | ☐ HIV/AIDS information |

☐ Other: _____

**Signature** _____**Date**_____

**Relationship if other than patient:** _____

This release is subject to the revocation at any time effective from the time it is communicated to the health care provider. If not revoked, the release terminates in accordance with HIPPAA Public Law 104-191.

***This form can be downloaded from http://www.susanlemagiemd.com/release.pdf***