DR. WM. DAVID MOORE
Women's HealthCare LLC

1127 N. Western Ave.
Marion, IN 46952
p: 765.662.4666
f: 765.662.4106

Patient Authorization for Release of Medical Records

REQUEST FOR RECORDS MUST BE RECEIVED BEFORE 12/20/2022
AFTER THIS DATE, A RECORDS CUSTODIAN WILL HANDLE THIS REQUEST.

SSN:_____

Patient Name: _____ DOB: _____/_____/_____

Address: _____

I _____, hereby voluntarily authorize the disclosure of information from my health record.

The information is to be disclosed to:

❑ NAME OF PHYSICIAN: _____ Phone _____

ADDRESS: _____CITY_____STATE_____ ZIP _____

OR ❑ SELF There is a $20 fee for records released directly to patient.
Records released to Patient can be picked up or mailed to your address on file.

The purpose for this disclosure is: ❑ Transfer of Care/ Continuity of Medical Care

The information to be disclosed from my health record is:

❑ Operative Reports ❑ Pap Smears ❑ Pathology Reports ❑ Mammograms ❑ DEXA Scans

❑ Progress Note Summary ❑ Ultrasound Reports ❑ Delivery Notes MGH

❑ Other _____

If you would like any of the following sensitive information disclosed, check the applicable box (s) below:

❑ Sexually Transmitted Diseases _____ Initial here

❑ HIV Test Results _____ Initial here

_____ _____

SIGNATURE OF PATIENT **DATE**

_____ _____

SIGNATURE OF LEGAL GUARDIAN **DATE**

RELATIONSHIP TO PATIENT

❑ Parent ❑ Legal Guardian ❑ Health Care Representative ❑ Other_____