WOMEN'S HEALTHCARE PARTNERS

DR. ELIZABETH OTTMAN MD, FACOG

LISA WIMSATT APRN, CNM

MISTY POWERS APRN, WHNP

2851 New Hartford Road Suite B, Owensboro, KY 42303
Phone: (270)688-6035 Fax: (270)688-6056

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize Dr _____ to release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

***** IF THE PATIENTS CHART IS MORE THAN <u>30</u> PAGES, PLEASE <u>DO NOT FAX</u> RECORDS, MAIL TO OUR ADDRESS. Thank you**
*****PLEASE SENT <u>CD</u> OF RECORDS IF POSSIBLE.**

☐ Yes ☐ No I authorize the release of my 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 I 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.

Patient Signature: _____ Date Signed: _____

Witness/Staff:_____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.