

Request and Authorization to release information

FROM a treating Physician **TO Coastal Womens Healthcare, PA**

Patient's Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____ Phone: _____

I hereby authorize the release of copies of my medical records concerning my illness, treatment or recommendations while a patient at the medical facility, **during the dates of:** _____

These records should be released:

From:

Name: _____ Phone Number: _____

Address: _____ Fax Number: _____

To: Coastal Womens Healthcare, PA
96 Campus Drive, 3rd Floor
Scarborough, Maine 04074

I request the following information be released *(last three years unless otherwise specified):*

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Annual Exams | <input type="checkbox"/> Office Visits | <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> Obstetrical Reports | <input type="checkbox"/> Lab Results | <input type="checkbox"/> Mammogram Films | <input type="checkbox"/> Procedure Reports |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Ultrasound Report | <input type="checkbox"/> Mammogram Reports | <input type="checkbox"/> Pathology Reports |
| <input type="checkbox"/> Operative Reports | <input type="checkbox"/> Sonogram Report | <input type="checkbox"/> Other _____ | |

If I have been diagnosed or treated for any of the following, I understand my specific consent is required by state law to release related information that may be contained in the above records:

Mental Health	_____ I DO Authorize	_____ I DO NOT authorize
Alcohol and Substance Abuse	_____ I DO Authorize	_____ I DO NOT authorize
Mental Health Services	_____ I DO Authorize	_____ I DO NOT authorize

Signature of Patient or Legal Representative Relationship to Patient Date