

**WHA, P.A. pka CAPITAL AREA OBSTETRICS & GYNECOLOGY ASSOCIATES
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

Print Patient's Full Name

Date of Birth

Street Address

Social Security Number

City, State, Zip Code

Daytime Phone Number

RELEASE RECORDS FROM: _____

Name of Company/Agency/Facility/Person

Street Address including Suite #

City, State, Zip Code

Telephone Number

Fax Number

SEND RECORDS TO:

Women's Health Alliance, PA pka Capital Area Ob/Gyn

1110 SE Cary Parkway, Suite 200

Cary, NC 27511

Phone # (919) 467-2249 Fax # (919) 861-0495

4414 Lake Boone Trail, Suite 308

Raleigh, NC 27607

Phone # (919) 781-7450 Fax # (919) 861-0495

RELEASE INFORMATION PERTAINING TO:

Pregnancy Gynecology Visits Operative Notes Discharge Summary
 Progress Notes Pathology Reports Laboratory Reports Emergency Reports
 Radiology Reports ECG/EEG/Cardiac Cath Other _____

PLEASE CHECK ONE

RELEASE ALL INFORMATION: _____ Release information from _____ to _____

I DO I do NOT authorize release of information related to Aids or HIV infection,
Psychiatric care and/ or psychological assessment, and
treatment for alcohol and/or drug abuse.

PURPOSE OF DISCLOSURE: Insurance Legal Investigation Workers Comp

Disability Determination Personal Change of Doctor Continuing Care

I hereby authorize disclosure of health information for the above named patient. This authorization is valid for 12 months from the date of signature unless otherwise noted. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized or furnished may not condition its treatment of me on whether or not I sign the authorization.

SIGNATURE of individual, guardian or
Personal representative of patients estate

Date

PLEASE NOTE: THERE IS A CHARGE FOR MEDICAL RECORDS. BACTES IS THE CONTRACTOR TO PROVIDE THIS SERVICE AND WILL INVOICE YOU DIRECTLY.