WOMEN FIRST, LLC

Maternity & Gynecology
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REQUEST FOR RECORDS RELEASE

PLEASE ALLOW MINIMUM OF 7 TO 10 BUSINESS DAYS FOR FORMS TO BE COMPLETED. **THERE IS A MAXIMUM FEE OF $30.00.**

TO:_____

_____

I hereby authorize you to release medical records on:

Patients Name:_____

Date of Birth:_____

Social Security # _____

Please mail records to:_____

_____

_____

Purpose of Release:

_____ Medical Care _____ Personal Information

_____ Insurance _____ Other _____

Information Needed:

_____

_____

Patient Signature or Representative _____

Date _____