WOMEN LIVING WELL
OBSTETRICS & GYNECOLOGY

RELEASE OF MEDICAL RECORDS

Patient's Name: _____

Date of Birth: _____ Social Security: _____

Other Name (ex: maiden name): _____

Previous Healthcare Provider:

Name: _____

Address: _____

_____

_____

Fax Number: _____

I hereby authorize and request you to release my complete medical records to:

Women Living Well
6300 Limestone Road
Suite A & B
Hockessin, DE 19707
302-635-9800 phone
302-239-2001 fax

I understand that the Medical Records to be released may contain information related to HIV status, AIDS, venereal diseases, alcohol or drug use or mental health services. I hereby authorize release of this information.

Patient Signature: _____ Date: _____