

Women's Healthcare of Southern Indiana
5300 State Rd. 64, Suite 103
Georgetown, IN 47122
Phone: (812) 923-6200
Fax: (812) 923-6204

Authorization To Request Medical Information

To: _____

Re: _____ Maiden Name: _____

Birth Date: _____ SS# _____

I hereby authorized the release of the information checked below to the Women's Healthcare of Southern Indiana, 5300 State Rd. 64, Suite 103, Georgetown, IN 47122. I am aware that this may include information concerning psychiatric problems, drug or alcohol abuse. HIV infection, or sexually transmitted diseases.

Dates of service and specifically requested information include the following.

_____ History and Physical	_____ Discharge Summary
_____ Operative Notes	_____ Family Planning Notes
_____ AIDS/HIV Records	_____ Pap Smear Report
_____ Prenatal Progress Notes	_____ Laboratory Reports
_____ Ultrasound Report	_____ Other
_____ Complete Medical Record Dating _____	to _____

The purpose for needing this information is _____

I understand that this consent is subject to revocation by me at any time and that it automatically expires (1) year after the date signed below.

Patient Signature: _____

Witness: _____

Date: _____