|  |  |
| --- | --- |
| PATIENT NAME & DOB : |  |
| ADDRESS: |  |
| CITY, STATE, & ZIP: |  |
| DATES OF SERVICE: | **ALL** |
| Patient Signature/ Legal Representative: | X |
| Relationship to patient: |  |

|  |
| --- |
| Release from:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Previous Gynecologist / PCP) Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

Information Requested:

\_\_\_\_Radiology Reports \_\_\_\_OP Reports \_\_\_\_Implant Log

\_\_\_\_H & P \_\_\_\_Inpatient Records \_\_\_\_Physician Progress notes/orders

\_\_\_\_Nurse Notes \_\_\_\_Admit or D/C summary \_\_\_\_Therapy Notes

\_\_\_\_Laboratory Reports \_\_\_\_Other: Specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_X\_\_ENTIRE CHART

With-in **7** business Days the **INFORMATION IS TO BE RELEASED TO:**

**Woman’s Health Center**

9301 Connecticut Drive

Crown Point, IN. 46307

Phone: 219-796-4060

 Fax: 21-756-8007

**The purpose of the disclosure:**

Continuation of Care \_X\_\_ Personal Use\_\_\_\_ Insurance\_\_\_\_ Attorney\_\_\_\_