



Full Circle Women's Health

450 Mamaroneck Avenue, Suite 414, Harrison, NY 10528
t: 914.421.1515 f: 914.421.1501 email: medicalrecords@fullcirclewh.com

MEDICAL RECORDS RELEASE FORM TO NEW PROVIDER

Patient Name: _____

Patient Address: _____

Home #: _____ Work #: _____ Cell #: _____

Birth Date: _____ Social Security No.: _____

Please send a copy of my medical records:

TO: _____

FROM: Robin Bradley MS, CNM
Michelle Chiafulio, CM
Full Circle Women's Health
450 Mamaroneck Avenue
Suite 414
Harrison, NY 10528

Fax #: _____

Please specify which medical records you want released and/or dates of service:

Annual exam and pap smear

Surgical records

Pregnancy/Prenatal

Sonograms and Labs

All medical records

Other

I understand that my medical records are protected under State and Federal confidentiality regulations. Disclosure of information regarding drug and/or alcohol abuse and treatment, confirmed sexually transmitted infections, including testing or treatment of HIV/AIDS and diagnosis of mental illness or psychiatric care cannot be released without my written consent.

This consent can be revoked by me at any time unless action has been taken in reliance on it. If not previously revoked, this consent will terminate in 180 days.

I further authorize and request that you accept a faxed copy of this authorization as the original.

Signature

Date

Witness

Date