
4604 Spotsylvania Parkway, Suite 310
Fredericksburg, VA 22408
Office: (540) 710-1700 Fax: (540) 710-1800

# AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

To: _____

Phone: _____ Fax: _____

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security#: _____

I request and authorize to release healthcare information to the following parties:

Name: Advanced Care for Women
Address: 4604 Spotsylvania Parkway, Suite 310
Fredericksburg, VA 22408

This request pertains to the following information:

☐ Healthcare information relating to the following treatment, condition or dates: _____

_____

☐ All healthcare information

☐ Other: _____

☐ Yes ☐ No I authorize the release of STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION IS VALID FOR A PERIOD OF ONE YEAR