WOMEN'S CANCER AND SURGICAL CARE, P.C.

4610 Jefferson Lane NE **Albuquerque, NM 87109**
Tel: (505) 559-4495 **Fax: (505) 842-8025**
Email: info@wcscnm.com **www.wcscnm.com**

Patient Name: _____ DOB: _____/_____/_____

I hereby request and authorize Women's Cancer and Surgical Care, PC to:

☐ **RELEASE** Information ☐ **OBTAIN** Information

Name of Provider/Facility_____

Address: _____

Telephone: (_____)_____ Contact Person: _____

The purpose of this release is: (check all that apply)

☐ Moving ☐ Insurance Purposes ☐ Transferring Care

☐ Second Opinion ☐ Personal Review

☐ Other (please specify)_____

The following Protected Health Information (PHI) may be released: (please check one)

☐ I consent to the release of ***all medical records*** with the following exceptions, (Specifically describe the information you do not wish to have released)

_____

☐ I consent to the release ***all medical records*** relating to the following treatment and Condition:

_____

☐ I consent to the release of ***all medical records*** from _____to_____

This authorization will automatically expire within one year from the date of signature. I understand that I have the right to revoke this authorization in writing at any time, except where information has already been released in response to this authorization.

NOTICE TO PATIENT: The first 50 pages are free of charge. After that there is a fee of $0.50 per page for copying and administrative costs up to a maximum of $80.

Signature of Patient / Representative / Legal Guardian Date