Triad Women's Health & Wellness Center

Women's Health

3750 ADMIRAL DRIVE, STE 104

HIGH POINT, NC 27265

PHONE (336) 841-6574, FAX (336) 841-6906

CONSENT FOR RELEASE OF MEDICAL RECORDS

FROM: Patient's Name _____

Patient's Address _____

Patient's Birth Date _____

Patient's Social Security Number _____

To: _____

_____

_____

I, do hereby consent and authorize you to release copies of my medical records, including current and previous medical records from other practices and practitioners, hospitals, and/or clinics which are a part of my medical records. PLEASE NOTE: This authorization includes consent for the release of alcohol, drug, psychiatric and psychological information; and any information relating to HIV Testing, AIDS, and AIDS-Related Syndromes which may be included in my records. It also may include information concerning, Cancer, Cancer Testing, and Cancer Results. I agree that a copy of this release or a fax of this release shall be as valid as this original release. Please send copies, either by mail or fax, of all requested information as soon as possible to the address listed below:

☐ SEND ALL MY RECORDS

☐ SENSITIVE INFORMATION HAS BEEN DELETED AT THE PATIENT'S REQUEST

☐ SEND RECORDS FROM (DATE) _____ TO (DATE) _____

SEND RECORDS TO:

Triad Women's Health and Wellness Center
3750 Admiral Dr., Suite 104 Premier Drive
High Point, NC 27265

_____

Patient's Signature

_____

Date

_____

Witness