



HEARTLAND WOMEN'S HEALTH CARE, P.C.

RELEASE OF MEDICAL RECORDS FORM

Date _____ Med Record # _____ Exp Date _____

Patients Last Name _____ First _____ MI _____

Date of Birth _____ Soc Sec # _____ Prev Last Name _____

New Address _____

City _____ State _____ Zip _____

New Home Phone _____ Cell Phone _____

I Hereby Authorize and Request My Medical Records Be Released

TO FROM

Heartland Women's Health Care, P.C.
2790 Clay Edwards Drive, Suite 530
N. Kansas City, MO 64116
Fax: 816-453-0677

TO FROM

Fax: _____

Release All Records Records From _____ To _____

Pap Smears Progress Notes Pathology Operative Reports

Purpose of This Release

Physician Request Moving Insurance Co Legal

Other _____

This facility, its employees, officers and the physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized. The PHI requested above will not be used for any other reason than to provide direct patient care. The patient may revoke this authorization at any time in writing. Revocation will not apply to information already disclosed in response to this authorization.

Charges may apply for copies of records. Please allow up to 10 business days for copying.

Patient Signature

Date

Witness

Records Copied By

Records were: Picked up Faxed Mailed on _____