RELEASE OF MEDICAL INFORMATION

Patient's Name: _____
DOB: _____
Address: _____
Address 2: _____
City/State/Zip _____
Phone: _____

Athena Record Number:

I hereby authorize that the protected health information about the patient named above may be forwarded from

Artemis for Women
2600 Roosevelt Rd Suite 2006
Valparaiso IN 46383

To Person/Business: _____
Address: _____
Address 2: _____
City/State/Zip _____
Phone: _____ Fax: _____

For the purpose of: □ Transferring Care □ Care Team Sharing □Other

Records to send: □ All □ Ultrasound Reports □ Prenatal Records

I wish not to disclose: □ HIV Records □ Psychiatric/ Psychological Record
□ Drug/Alcohol Abuse Records

I understand that there is a $30 fee for the office to print records. This fee is not covered by health insurance. □ Cash □ Check □ Credit/Debit Card

_____ _____
Patient Signature Date

_____ _____
Witness Date