

Authorization to Release Medical Information

I _____ hereby request that my medical records, or copies
Patient Name (Please Print)

of such, be released and sent to:

Martinsville Women's Health, LLC
784 Chimney Rock Rd., Suite G
Martinsville, NJ 08836
TEL: 732-271-1771
FAX: 732-271-9477

I understand that the information to be disclosed may include the following unless crossed out by me:

- Drug and alcohol abuse information
- Information regarding Human Immunodeficiency Virus (HIV), including laboratory test results
- History and Physical Examinations
- Consultations
- Genetic testing and counseling
- Diagnostic testing
- Psychosocial history
- Treatment recommendations

Please send:

All medical records
Operative reports
Lab and Diagnostic results
Other (specify): _____

Patient Signature: _____ Date: _____

Patient Birth Date: _____