Littleton Gynecology & Wellness

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's Name:__________________________________ Date of Birth:________________________

Phone Number: ____

Purpose for this request: (check one)

Personal ☐ Transfer of Care ☐

Type of Records Requested: (check one)

☐ All Medical Records (as allowed by law) ____

- I Authorize the release of HIV and STD results and psych notes _______________________
  (Signature)

☐ Specific Information: ____

Office Name:____

Street Address:____ Suite #:_________________

City:____________________________ State: __________________ Zip Code: ______________

Phone:_____________________________ Fax:____

☐ **TO SEND MY MEDICAL RECORDS TO LITTLETON GYNECOLGY & WELLNESS AT THE ADDRESS ABOVE.**

☐ **LITTLETON GYNECOLOGY & WELLNESS TO SEND MY MEDICAL RECORDS TO THE ABOVE NAMED DOCTOR'S OFFICE.**

Patient Signature______________________________________ **Date** ______________________