Women's Wellness Center & Medical Spa
1400 Peoples Plaza Suite 301
Newark, Delaware 19702
Ph (302) 643-2500
Fx (302) 836-2813
www.vitalityhealthde.com

Consent to Release Medical Information

I hereby request that the following medical information be transferred

From:
_____
_____
_____
Fax: _____

To:
Women's Wellness & Medical Spa
1400 Peoples Plaza Suite 301
Newark, Delaware 19702
302-643-2500

Patient Name (list all names used in past) _____
Patient Birth Date _____ Social Security No. _____

Patient Address _____

Patient Phone Number(s) _____

I authorize the above doctor/practice to release information contained in my patient records, including, as applicable: Information about communicable diseases and infections which may include sexually transmitted diseases, psychiatric notes, alcohol abuse, drug abuse, HIV test results, and AIDS or AIDS related disease diagnosis, unless otherwise specified here _____

Information Requested: Dates of Treatment to be Released FROM _____ TO _____

From All Providers From Specific Provider(s): _____

WWC Records Only Hospital Records Pap Results

Operative/Pathology Reports Labs Mammogram Results

All Records

Records related to the specific problem of _____
_____
_____

Our Patient Privacy Policy is available on our website at www.vitalityhealthde.com or you may request a copy be mailed to you.

I understand that this authorization shall be valid for one year, unless otherwise specified or revoked by me through written notice, and that such revocation would not be effective to the extent that the practice has relied on this authorization for its actions.

_____ _____

Patient Signature Date