Genis Women's Care, PC
2790 Godwin Blvd # 375
Suffolk VA 23434
757-923-4500
757-923-4607 Fax

Authorization to Release Medical Records

Patient Name(L, F,MI):_____

Date of Birth:____/____/_____ Social Security Number:_____

Address:_____

City:_____ State:_____ Zip:_____

Reason for release of medical records:_____

Please check one of the following: **Note that your complete medical history will be sent unless otherwise specified**

_____ Please release my medical records to myself.

_____ Please release my medical records to Genis Women's Care, PC from the location listed below.

_____ Please release my medical records from Genis Women's Care, PC to the following location:

Dr. Name or Practice Name: _____

Mailing address: _____ City:_____

State:_____ Zip:_____ Phone:_____

Fax:_____

Signature:_____ Date:____/____/_____