Premier
Women's Health

REQUEST FOR RELEASE OF MEDICAL RECORDS

TO: Premier Women's Health
301 Ohio River Blvd., Suite 301
Sewickley, PA 15143

I HEREBY AUTHORIZE THAT MY MEDICAL RECORDS BE RELEASED TO:

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Please include the following information:

_____ All Medical Records

______ Operative Report

______ Discharge Summary

______ Pathology Reports

______ L&D, Prenatal Records

______ HIV and/or mental health records

______ OTHER ________________

Reason for release:

_____ Insurance Change

_____ Second Opinion

_____ Transferring Physician

_____ Moving out of area

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PRINT Patient's Name   Date of Birth   Social Security #

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Signature   Date   Witness