GREEN HILLS COMMUNITY ACTION AGENCY (GHCAA)
1506 Oklahoma Avenue ~ PO Box 278 ~ Trenton, MO 64683
TDD Relay Missouri: 1-877-611-7600
Phone: 660-359-2855 ~ Fax: 660-359-2855

WOMEN'S HEALTH SERVICES

MEDICAL RECORDS RELEASE FORM

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or summary or narrative of my protected health information, to the physician/person/facility/entity listed below.

PATIENT NAME:_____DATE OF BIRTH:_____

HIV/AIDS: I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS, or infection with any other causative agent of AIDS with the rest of my medical records. **Initial**:_____**Date**:_____

The information you may release subject to this signed release form is as follows:

☐ Complete records ☐ History & Physical ☐ Progress Notes ☐ Care Plan

☐ Lab Reports ☐ Radiology Reports ☐ Pathology Reports ☐ Treatment Record

☐ Medication Record ☐ Other (please specify) _____

Records are requested from:_____

Release My Protected Health Information To The Following Physician/Person/Facility/Enitity:

Name:_____Fax Number:_____

Address:_____Telephone Number:_____

City:_____State:_____Zip Code:_____

This authorization shall expire no later than ___/___/___. (May not be valid for greater than one year)

_____ _____

Signature of Patient Date

_____ _____

Signature of Witness/Title Date

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