MADISON
WOMEN'S HEALTH & FERTILITY, PC

REQUEST FOR ACCESS TO HEALTH INFORMATION

I hereby authorize the release of the following protected health information with the specified date(s) from the gynecological care that I received under the care of Drs. Matera, Moomjy and/or Brown:

__Office Notes	**__Laboratory**	**__Radiology**	**__Other_____**
__/__/__-__/__/__	__/__/__ - __/__/__	__/__/__ - __/__/__	__/__/__ - __/__/__

The Purpose of this request is:

__Transfer of care **__Personal records** **__Share with MD** **__Insurance purposes**

Include **HIV/AIDS** testing and related information __Yes __No __N/A

Confidential HIV Related Information is any information indicating that a person had an HIV related test, or has HIV infection, HIV related illness or AIDS, or any information which could indicate that a person has been potentially exposed to HIV. *Please be aware that this may comprise a significant component of your records given the nature of gynecologic care, i.e. sexual activity is a potential risk factor for HIV exposure.*

Other restrictions: None *(please circle)* or _____

We charge fees for copy and postage, as permitted by applicable state and federal laws. You will be informed of the total due before your copies are provided to you.

Please send via Fax/USPS/FedEx *(fess will apply)*/Pick-up ***(please circle)*** my health information to:

Name _____

Address _____

Phone/Fax_____

By signing this form I am authorizing the use and disclosure of my protected health information. All of my questions about this form have been answered. I understand that I can refuse to sign this authorization and I can revoke the authorization at any time before the information has been released (by submitting a written notification of revocation). I release the physicians and employees from liability for any consequences that are related to this request.

_____	_____
Patient Signature	**Witness Signature**
_____	_____
Patient Name and Date of Birth	**Witness Name**
_____/_____/_____	_____/_____/_____
Date	**Date**