Ashley A. Hudson, MD
Christa S. Littrell, DO
Jeanine M. Loncar, MD
Victoria B. Perkins, MD

David L. Rushing, MD
Karen Leigh Samples, MD
Shanna V.N. Shumaker, MD
John David Wheeler, MD

Clinic for Women

OBSTETRICS AND GYNECOLOGY
FELLOWS OF THE AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

Authorization for Release / Request of Protected Health Information

Patient's Name: _____ Date of Birth: _____

Address: _____

City/State/Zip Code: _____

SS #: _____ Patient's Phone Number: ( )_____

Date of Request: _____ Date Needed: _____

Please be aware requests can take between 7 to 10 days to be fulfilled.

☐ I authorize Clinic For Women to release information to:

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone # / Fax # (Include Area Code)

OR

☐ I authorize Clinic For Women to obtain information from:

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone # / Fax # (Include Area Code)

Purpose For This Request: (Check One) ☐ Healthcare ☐ Insurance Coverage ☐ Personal ☐ Other

Type of Records Requested: (Check One)

☐ Specific Information (Select one or more, as applicable)

☐ Operative Report ☐ History & Physical ☐ Consult
☐ Lab Test Results ☐ X-Ray Reports ☐ Discharge Summary
☐ Office Notes ☐ DEXA results ☐ MMG

☐ All medical records related to a specific injury or illness:
_____ (specify illness / injury) _____ (date of treatment)

I understand that:

- My right to healthcare treatment is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a written request to the address provided at the bottom of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be re-disclosed.
- Release of HIV-related information, mental health related care, or substance abuse diagnosis and treatment information requires additional authorization.
- Expiration date: _____

Please note: Medical records are faxed in cases of medical necessity only.

Signature of Patient: _____ Date: _____

The Women's Pavilion
910 Adams Street, Suite 300
Huntsville, Alabama 35801
Telephone: (256) 533-7420
Facsimile: (256) 536-4109

Last updated: 8/22/24