

DOCTORS OF WOMEN MEDICAL HEALTH CENTER  
4050 BARRANCA PARKWAY, SUITE 160  
IRVINE, CA. 92604

RECORDS RELEASE REQUEST

Date of Request \_\_\_\_\_

Date of Birth \_\_\_\_\_

I \_\_\_\_\_, am requesting a copy of my medical records for

my personal file

my primary MD

transferring care

\_\_\_\_\_

I would like the records listed below to be included.

lab results ( including HIV if applicable )       all     most recent

pap smear result       all     most recent

ultrasound report       all     most recent

mammogram report       all     most recent

other records requested \_\_\_\_\_

I will pick up my records at Doctors of Women

I would like my records faxed to       my personal fax: \_\_\_\_\_

my primary MD.'s fax \_\_\_\_\_

\_\_\_\_\_ fax \_\_\_\_\_

Attention: \_\_\_\_\_

Phone number: \_\_\_\_\_

I can be reached at the above number by your records department when records have been faxed or are ready to be picked up.

**In compliance with HIPAA regulations, Doctors of Women provides our patients with access to their protected health information within 15 days of the patient's written request.**

**For records available in our office, Doctors of Women imposes a standard fee of \$17.00. For records in storage, Doctors of Women charges a \$35.00 fee to cover our cost for retrieval.**

paid \$ \_\_\_\_\_ Date \_\_\_\_\_  cash  check  credit card

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date