Woman Care OB/GYN

Dr. Lourice David
Dr. Alice Serou
Dr. Katherine Betcher
Kate Rasmussen, WHNP

Payment:There may be fees associated with most record requests.
Payment must be received before records can be released.

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name _____ Maiden Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Phone _____

I authorize Woman Care OB/GYN to:

_____ Release my records to _____

_____ Release my records from _____

Address _____ City _____ State _____ Zip _____

Phone _____ Fax _____

Appointment has been scheduled on _____ Appointment Pending _____

Reason for Release _____

_____ I am transferring care
_____ I AM NOT transferring care

Please check ALL that apply:

_____ Office Notes _____ Lab _____ Immunizations
_____ Imaging & Diagnostics _____ Op Notes _____ Other _____
_____ Progress Notes _____ ALL

Please specify Exact Date Range _____

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Signature of Witness Date

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