Name:
Chart:
Date:

## Release of Medical Record Information

**Catawba Women's Center, P.A.**
Attention: Medical Records
PO Box 38
Hickory, NC 28603-0038
Phone: 828-322-4140
Fax: 828-322-3767

Patient Name ______ Social Security # ______ Date of Birth ______

Previous name(s) (if applicable): ______

Specific description of the information to be used or disclosed: ______

______

**Complete (1) applicable section below:**

Initial: ______ I hereby authorize **Catawba Women's Center, P.A.** to release the above-mentioned information to the Person/Organization listed below.

Business Name ______

Phone # ______ Fax # ______

Initial: ______ I hereby authorize the following hospital/medical office to release the above-mentioned information to **Catawba Women's Center, P.A.**

Business Name ______

Phone # ______ Fax # ______

The purpose of the use or disclosure is: ______

Effective Date of Release: ______ Release Expires: ______

Signature of patient or *patient's representative** ______ Date ______

**Printed name of patient's representative, if applicable* ______ *Representative's authority* ______