

# WOMEN'S CARE CENTER OF COLUMBUS, INC.

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(614) 475-0811

## REQUEST FOR RELEASE OF MEDICAL RECORDS

I authorize \_\_\_\_\_  
NAME OF FACILITY OR PRACTICE

to release information regarding \_\_\_\_\_ to  
PATIENT

**WOMENS CARE CENTER OF COLUMBUS, INC.**  
**1375 Cherry Way Drive Suite 110**  
**Gahanna, Ohio 43230**

### Information to be released (clearly describe)

\_\_\_\_\_  
\_\_\_\_\_

### Purpose of release:

\_\_\_\_\_  
\_\_\_\_\_

**Expiration:** This authorization will expire on \_\_\_\_\_ (specific date) or when  
\_\_\_\_\_ (event or purpose related to disclosure)

**Revocation:** The patient may revoke this authorization in writing at any time, except to the extent that the Medical Practice has acted in reliance on this authorization.

**Redisclosure:** Information used or disclosed under this authorization will be given to recipients who may redisclose the information and those later disclosures may not be protected by law.

**Patient's Rights:** The patient may inspect or copy the protected information used or disclosed pursuant to authorization and may refuse to sign this authorization. Except where allowed by law, the Medical Practice will not condition treatment, payment or other health care benefits on the giving of this authorization.

**HIV, Mental Health and Drug & Alcohol information contained in the parts of the records indicated above will be released through this authorization unless otherwise indicated. Do not release: \_\_\_ HIV, \_\_\_ Drug & Alcohol \_\_\_ Mental Health (Psychiatric)**

\_\_\_\_\_  
SIGNATURE OF PATIENT OR GUARDIAN (if minor)

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PATIENT'S SOCIAL SECURITY NUMBER

\_\_\_\_\_  
PATIENT'S DATE OF BIRTH