

Lauren F. Hamilton, M.D.  
Denise H. Devine, M.D.  
W. Stanley Ottinger, M.D.  
Heidi M. Sapp, M.D.



Charleston  
OB/GYN

Monica J. Mitchum, M.D.  
Elizabeth A. Richardson, M.D.  
Jessica F. Wade, M.D.  
Mai N. Dyer, M.D.  
Jennifer A. Winkler, CNM

**AUTHORIZATION FOR RELEASE/REQUEST OF MEDICAL INFORMATION**

Patient's Full Name: \_\_\_\_\_

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

Street Address: \_\_\_\_\_

SSN#: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

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

**Request Information From:**

**Release Information To:**

\_\_\_\_\_  
Name of Company/Agency/Facility/Person

\_\_\_\_\_  
Name of Company/Agency/Facility/Person

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City/State/Zip

\_\_\_\_\_  
City/State/Zip

\_\_\_\_\_  
Phone / Fax

\_\_\_\_\_  
Phone / Fax

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Authorize Release of Information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment and treatment for alcohol and/or drug abuse.

Yes \_\_\_ No \_\_\_

Information Needed For: Attorney \_\_\_ Insurance Company \_\_\_ Self \_\_\_ Other \_\_\_\_\_

Is this also a transfer of your medical care? Yes \_\_\_ No \_\_\_\_\_

Records to be: mailed \_\_\_\_\_ faxed to: \_\_\_\_\_

picked up \_\_\_\_\_ emailed to: \_\_\_\_\_  
(please print legibly)

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Complete Record \_\_\_\_\_

Partial Record \_\_\_\_\_  
(Indicate info needed and date range...for example, MRI reports 2006, Op Note from 06-13-07...etc.)

Signature: \_\_\_\_\_ Witness: \_\_\_\_\_ Date: \_\_\_\_\_

Please allow at least 7-10 business days for your request to be completed. Charges may apply.  
Records are transferred to other physicians as a courtesy; charges will apply when sent directly to patient.  
This authorization expires 90 days from date signed.