



Authorization Request for Medical Information

I, _____, do hereby consent and authorize Blue Ridge Women's Center, P.A. to request and obtain my medical records relating to my identity, diagnosis, prognosis and treatment, including but not limited to treatment of drug and alcohol related illness, psychiatric treatment, diagnosis and/or treatment of HIV illness.

I understand the extent or nature of the medical information to be disclosed includes:

Furthermore, I understand that this authorization is revocable by me at any time I provided a written, signed notice of the revocation to Blue Ridge Women's Center, PA, except to the extent that any action has been taken on this release. Otherwise, this consent will expire within one year from date of signature.

Special limitations or instructions (if any): _____

Signature of Patient Date
Or Legal Representative

Signature of Witness Date

Patient SS#: _____

Patient Date of Birth: _____

Patient Address: _____

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