AUTHORIZATION TO RELEASE MEDICAL RECORDS:

ONE TO ONE FEMALECARE, PA, 111 Madison Ave., Suite 305, Morristown, NJ 07960
PHONE # 973-683-1400, FAX 973-683-0700

I, _____, hereby authorize One to One FemaleCare,
PRINT NAME/INCLUDE MAIDEN IF APPLICABLE
PA to release my medical records to:

_____
NAME

_____
ADDRESS

_____

_____
PHONE FAX

Pt. Address: _____

_____

Telephone: _____ Pt. Date of Birth: _____

Reason for Request:

_____ Moving out of area _____Changing OB/GYN/not returning

_____ Second Opinion _____Consultation Only

_____ Copy Records to Primary or Specialist

Due to the increased costs associated with running a medical practice, it has become necessary that we institute a minimum $10 fee for any chart that is 10 pgs. or less. A $1 per page fee will be issued for all records thereafter. The payment must be paid at the time of the request before the copy is released. If we are referring you to a specialist the fee is not applicable. This release is valid for only one set of records. Any additional sets will apply the same financial arrangement. Please realize that we are only allowed by the provisions of HIPPA to release that part of your medical record that applies to the care you have received while under our care at ONE to ONE FemaleCare, PA. Please also take note that we have thirty days to release copies of your medical records. We make every effort to respond to your request in a timely fashion. Your cooperation is much appreciated.

_____ _____
Patient Signature Date of Request