

Partners in Women's Health

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(561) 354-1515
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Release of Medical Records

I, _____
Patient name (please print)

Date of Birth: _____ Social Security #: _____

Hereby Request That My Records Be Released From:

Partners in Women's Health
600 Heritage Drive Suite 210
Jupiter, Florida 33458
Phone(561) 354-1515\
Fax(561) 354-1516

Requesting: All Records (including HIV test results)

Specific: _____

Records to be sent to: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone #: (____) - _____ Fax #: (____) - _____

Patient Signature: _____ Date: _____