Complete Healthcare

OB/GYN

Richard Lorenzo, DO ● Kortney Jones, ARNP

1045 Jadwin Avenue, Richland, WA 99352 ● 509-392-6700

Medical Records Release Form

Name: _____

Date of Birth: _____ Phone: _____

Address: _____

I give _____

authorization to disclose or release the following medical record(s):

All Medical Records ☐ Lab Results ☐ Radiology Reports ☐

Other Reports (specify): _____

Please **do not** include the following information if initialed:

Mental Health Diagnosis/Treatment information: _____

Drug & Alcohol Abuse Diagnosis/Treatment information _____

Sexually Transmitted Disease Diagnosis/Treatment information: _____

The above records are for services provided FROM: _____ TO: _____

Records are to be sent to:

Complete Healthcare for Women, PLLC
Richard Lorenzo, DO ● Kortney Jones, ARNP
1045 Jadwin Ave.
Richland, WA 99352
Phone: 509-392-6700
Fax:; 509-392-6699

This authorization shall expire on _____ or one year from the date originally signed.

I understand that this authorization is voluntary, and it gives the authorized person permission to use them as stated.

Signature: _____ Date: _____

Printed Name: _____

Please keep in mind that it may take up to two (2) weeks to process your request.