Dr. Kathy Wolf, M.D, F.A.C.O.G
Dr. Carolyn Davis, M.D, F.A.C.O.G
Dr. Mary N. Smith, M.D, F.A.C.O.G
Dr. Lauren Outlaw, M.D, F.A.C.O.G
Dr. Kimberly Oh, M.D.

Records Release Authorization

Date:_____________

Patient Name:_________________________________

Patient Date of Birth:_______________________

I give permission for my medical records to be released ☐ To **OR** ☐ From

Kathy E. Wolf, MD PC
Obstetrics and Gynecology
3299 Woodburn Road Suite 350
Annandale, VA 22003
Office Phone: (703) 260-1179
Secure Office Fax: (571) 405-6234

☐ To **OR** ☐ From:

Dr./Practice Name:____________________________________

Address:____

Office Phone:__________________________ Office Fax:_____________________________

I understand this consent is voluntary and that I may revoke this authorization at any time (except to the extent that action based on this consent has already been taken) by written, dated, and signed communication. This consent will remain in effect no more than ninety (90) days from the date I signed this consent. I also understand that my medical records may include mental health information, drug/alcohol information, and/or HIV information.
When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.
I understand I may refuse to sign this authorization. If I refuse, the identified records will not be disclosed. Whether I sign or refuse to sign, my treatment will not be affected.

Purpose or need for the information requested

Referral to specialist ______ Insurance ______ Legal ______ Disability Determination______

Transfer of Care to another practice ______ Relocation (out of area)______

Other (specify)______________________________

Unless otherwise specified, patient's entire chart will be printed. If entire chart is not needed/desired, please select items to be released:

- Office visit notes____
- Radiology reports_____
- Lab results_____
- Mammogram reports_____
- DEXA_____
- Other (specify)___________________________

Please be advised there is a fee of $35 for the first 49 pages and $50 for 50 or more pages.

Signature:____