WOMEN'S HEALTH ALLIANCE, P.A.
DURHAM WOMEN'S CLINIC
W. Barrett Gunter, M.D.
Denise M. Olson, M.D.
Frank A. Frenduto, M.D.
Ann-Bridget Bird, M.D.
Marcy S. Powell, M.D.
Toby A. Ritterhoff, M.D., FACOG
Cheryl Carroll, CNM, MSN, PMHNP-BC
Michele B. Kessler, PA-C
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Jualeah Early, MSN, CNM

209 East Carver Street
Durham, North Carolina 27704
Telephone: 919-471-CARE (471-2273)
Fax#: 919-479-0881

I Authorize Durham Women's Clinic to _____obtain from (or) _____release to:

_____
Name of Provider / Facility

_____
Records Requested

_____
Address of Provider

_____
City **State** **Zip Code**

_____
Telephone Number **Fax Number**

_____ _____
Signature of Patient **Date of Birth**

_____ _____
Social Security Number **Date**

Lic# / ID# _____ **Checked by**:_____

Durham Women's Clinic
209 East Carver Street
Durham, North Carolina 27704
Telephone: 919-471-CARE (471-2273)
Fax#: 919-479-0881

Authorization for Disclosure of Medical Information

Patient Name:_____

Date of Birth:_____ SS#:_____

I Authorize Women's Health Alliance, PA, Durham Women's Clinic to: ☐obtain from ☐release to

_____
Name of Provider

_____
Address

_____
City State Zip Code

_____
Phone Fax#

Information to be released/obtained_____

Duration of Authorization:
This Authorization will expire on the following date or time frame:_____ If no date is specified, this Authorization will expire 1 year from the date signed. This Authorization may be revoked at any time provided the revocation is a properly executed document and delivered to Women's Health Alliance, PA, Durham Women's Clinic at the above address. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal regulations.

_____ _____
Signature of Patient **Date**

_____ _____
Lic# or Photo ID# **Checked by**