The Group For Women

Dr. Gerow & Dr. Andrews

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Please print

_____

Patient Name | Other Last Names

_____

Date of birth | Phone Number | Email Address

_____

Street Address | City, State, Zip code

Transfer of care is required due to the closing of my physician's office. Therefore, I hereby authorize

Morgan Records Management LLC, 8 State Street, Nashua, NH 03063,

On behalf of**, The Group For Women, 1444 S Potomac St., Ste. 235, Aurora, CO 80012,** to execute one of the following:

Please select one of the following delivery options:

☐ Secure HIPAA approved electronic transfer: ***List email you want chart sent to here*:**

_____

☐ Disc mailed. We mail USPS Certified Return Receipt. ***List address you want disc mailed to here:***

_____

I, _____, am the patient or legal guardian who has authorization to release the above records. Any facsimile, copy, or photocopy of this release will be valid for 90 days and shall authorize you to forward my medical records. This form gives you permission to share my private information obtained from this facility. Only records from this facility can be legally released. Any records from other physicians must be obtained from them directly.

_____

Patient or Legal Guardian Signature | Date

Your completed authorization form may be emailed to Medical@MorganRM.com, or mailed to Morgan Records Management LLC, 8 State Street, Nashua, NH 03063.