The Women's Health Center of Hunterdon County (WHC)

Affiliates in Obstetrics and Gynecology, P.A.
111 State Route 31 Suite 121 Flemington, NJ 08822
908-782-2825

FAX release to 908-782-0196

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I understand that I will be charged a fee for the reproduction of records as follows: 20 pages or less, $10.00; more than 20 pages: $25.00. The WHC may also charge up to $10.00 to cover routine postage and/or postage for FedEx if requested.

Payment for records is due before records will be released. Records will be ready in 3-5 days upon receival of payment.

Patient Name:_____Date of Birth:_____

Home Address:_____

Home Telephone:_____Work/Cell:_____

I hereby request that WHC provide:_____

(Example: requesting physician name or "myself")

with my medical records created by the WHC.

( ) I am interested in obtaining a ***copy of all my records*** maintained by the WHC.

( ) I am only interested in obtaining copies related to the time period from_____to_____.

I would prefer to:

( ) Pick up requested information on:_____

( ) Have a copy mailed/emailed to:_____

I authorize the release of my information relating to genetic testing, sexually transmitted disease, AIDS/HIV, and behavioral/mental health information.

If I am a parent or legal guardian requesting access to the medical records of a child, I understand that, pursuant to law, certain limited records may not be available to me.

I understand that WHC may deny this request under limited circumstances as provided for under New Jersey law and federal regulations governing the protection of personally identifiable health information. I further understand that, except otherwise permitted under applicable federal law, I have the right to have a denial of my request reviewed by a licensed healthcare practitioner selected by WHC who did not participate in WHC's initial decision to deny my request.

Patient/Guardian Signature:_____Date:_____