Women's Healthcare Consultants

Jodie Rai, MD, FACOG
Obstertics/Gynecology

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD/INFORMATION

I hereby authorize _____ to disclose the following information from the health record of:

_____ _____
Patient name (printed) Date of Birth

Covering the period(s) of health care:
From (Date)_____ To (Date)_____

Information to be disclosed:
( ) Complete Health Record(s)
( ) History & Physical Examination
( ) Progress Notes
( ) X-Ray Reports
( ) Discharge Summary
( ) Consultation Report(s)
( ) Laboratory Test Results
( ) Other (specify)_____

I understand that this will include information relating to (check if applicable):
( ) Acquired Immunodeficiency Syndrome (AIDS) or infection with HIV (Human Immunodeficiency Virus)
( ) Psychiatric Care
( ) Treatment for alcohol and/or drug abuse

Release requested records to: **Jodie Rai, MD**
3009 N Ballas Road Ste 352 Building C
St Louis, MO 63131

I understand this authorization may be revoked at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire one year after the date indicated below.

The physicians named, and their employees are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

_____ _____
Signature /Patient Date

_____ _____
or (Legal Representative) (Relationship to Patient) Date

NOTE: Certified copy of appointment of legal guardian or personal representative and death certificate (if applicable) must be attached.

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Release of Information

In order to protect your privacy and maintain confidentiality, we require your consent to release medical information. Please list specific names of family members and/or friends that have permission to obtain information from this office regarding your diagnosis and care.

Name	Phone Number	Relationship to you
1.		
2.		
3.		
4.		

Please list all phone numbers that the office has permission to leave messages for you:

_____	Home	Cell	Work
_____	Home	Cell	Work
_____	Home	Cell	Work

Information may also need to be released to insurance or health care providers involved in your care. This may include faxing records, e-mail, telephone correspondence and mailings.

_____ _____

Signature Date

Name_____

MEDICAL HISTORY FORM

Please fill out this form as completely and carefully as possible. It will enable us to gain valuable information concerning your health history. It remains part of your confidential chart.

Who referred you to Dr. Rai? _____

Reason for visit: _____

_____

_____

Primary Care Physician: _____

Medications: List all current medications that you are taking or have taken in the last month.

_____ _____

_____ _____

_____ _____

_____ _____

Allergies to Medications: please list medication and reaction

_____ _____

_____ _____

_____ _____

Past Medical History:

Accidents: (list broken bones, injuries, etc)_____

_____

Illnesses: (requiring hospitalization, list problem and year)_____

_____

Operations: (list all and year)_____

_____

Have you or any of your relatives had cancer? If so, please specify:

_____

Name _____

GYNECOLOGICAL HISTORY

1. Age of onset of periods: _____

2. First day of last menstrual period: _____

3. Duration of your period: _____ days

4. Amount of bleeding: Light Moderate Heavy

5. Pain or Cramping: Mild Moderate Severe

6. Spotting in between periods: Yes No

7. Sexually Active: Yes No

8. Method of Birth Control: _____

9. History of sexually transmitted diseases (please circle all that apply)

Gonorrhea Syphillis Chlamydia Hepatitis B Herpes Condyloma (genital warts) HIV

10. Date of last pap smear: _____

11. Have you ever had an abnormal pap? Yes No
If yes, please give date: _____

12. Date of last mammogram: _____

OBSTETRICAL HISTORY

List all pregnancies, in order, including miscarriages and abortions

Year	Gender	Weight	Delivery Method	Anesthesia	Complications

Name_____

PERSONAL HISTORY

1. Marital status: Single Married Other

2. Education in number of years: _____

3. Occupation: Self _____
   Spouse _____

4. Place of employment: _____

5. Religious preference: _____

6. Smoking History: Number of years _____
   Packs per day _____

7. Drinking History: Number of years _____
   Ounces per day _____

8. Do you exercise? Yes No
   If yes, how often do you exercise? _____

9. List individuals who live in your home:_____
   _____

10. What additional information would you like the doctor to know about you?
    _____
    _____

Patient Signature _____

Date _____