

Women's Healthcare Consultants

Jodie Rai, MD, FACOG
Obstetrics/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:

- | | |
|---|--|
| <input type="checkbox"/> Complete Health Record(s) | <input type="checkbox"/> Discharge Summary |
| <input type="checkbox"/> History & Physical Examination | <input type="checkbox"/> Consultation Report(s) |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Laboratory Test Results |
| <input type="checkbox"/> X-Ray Reports | <input type="checkbox"/> 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.

Women's Healthcare Consultants

Jodie Rai, MD, FACOG
Obstetrics/Gynecology

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.

<u>Name</u>	<u>Phone Number</u>	<u>Relationship to you</u>
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 _____

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 _____