Release of Personal & Health Information and Medical Records
Request/Release and Consent for Treatment

Name: _____
(First, Middle, Last)

Address (Street)_____

(City)_____(State)_____(Zip Code)_____

Date of Birth: _____
Phone number: _____
Location of Service: _____
Email: _____
Date of Service: _____

I authorize the release and disclosure of any and all of Personal & Health Information, Medical Records, Prior Imaging to Women's Mobile Medical Services (WMMS), LLC for billing puposes, prior imaging requests, and I hereby Consent for Treatment by WMMS.

Insurance Coverage
It is your responsibility to be aware of your insurance coverage, policy provisions, exclusions and limitations as well as authorization requirements. This information is obtained by contacting your insurance carrier. We attempt to verify that your coverage is valid at the time of the visit. However, if your coverage is not in effect at the time of the visit, the financial responsibility for payment is yours. I have read and fully understand this Financial Responsibility Form. I acknowledge my personal financial responsibility and I consent to continue with treatment. No charge for the first CD: $20.00 for any additional copies.

I request my records release, prior imaging, reports and information be sent to, disclosed to, and used by, the following individuals or organizations:

Send images in DICOM Format CD and all reports ASAP.

Faxed reports appreciated: (407-349-2006)

WOMEN'S MOBILE MEDICAL SERVICES
760 VALLEY STREAM DRIVE
GENEVA, FL 32732

Other:_____
_____
_____

_____ _____
Patient Signature (Date)