



Women's Health For Life, Inc.

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770 West High Street, Suite 400
Lima, OH 45801

AUTHORIZATION FOR RELEASE AND EXCHANGE OF INFORMATION

I, _____, do hereby request and grant my permission for release and/or exchange of all information relating to my care from and to the parties named:

FROM:

TO:

WOMEN'S HEALTH FOR LIFE, INC.
Marilyn J. Kindig, D.O.
1005 Bellefontaine Ave Suite 175
Lima, OH 45804
Telephone (419) 227-2727
Fax (419) 227-2737

This information may include but is not limited to the following:

- Medical Summary Sheet
- Obstetrics and Gynecology Operative Reports
- (Pap smears, mammograms, etc.) from the last five years
- Chicken pox immunity

To assist in identification and location of my records, I am providing the following information:

Name used when treatment occurred: _____

Social Security Number: _____ Date of Birth: _____

Signature of Patient or Legal Guardian

Date