VIRAPEL™
Bioidentical Hormone Replacement Therapy

Female Release of Medical Records Consent Form

Please complete and send to your physician **PRIOR** to your upcoming appointment. It is **MANDATORY** for Dr. William Miller/ Cheryl Felt, MSN-APC-C to have your **current pap and mammogram report prior to your HRT appointment.**

Date: _____

To:

_____
Your Doctor's Name

_____
Address

_____
City State Zip

Phone: (_ _ _) _ _ _ - _ _ _ _

Fax: (_ _ _) _ _ _ - _ _ _ _

I, _____, authorize_____
(Your Name) (Your Doctor's Name)

to disclose and release any individually identifiable health information related to me **from the last 2 years only**, which is called protected health information (PHI) under a federal health privacy law, as described below (please check all that apply):

- ☐ Mammogram Report
- ☐ Pap Report
- ☐ Bone Density Report
- ☐ Endometrial Biopsy
- ☐ Ultrasounds
- ☐ Any current Hormone Labs

_____ _____
Print Name Date of Birth

_____ _____
Patient Signature Date

Report can be sent to Virapel-WBM Medical Associates, LLC
Attention Joan Mills, Office Administrator
602 Sheppard Road, Voorhees, NJ 08043
Or Fax to: 856-751-2106