



AUTHORIZATION TO RELEASE CONFIDENTIAL MEDICAL INFORMATION

Records cannot be released or obtained until this form is completed and signed by the patient or legal guardian.

1	PATIENT NAME: _____ DATE OF BIRTH: _____ First Last M.I. MAIDEN NAME: _____ PHONE NUMBER: _____ ADDRESS: _____ Street City State Zip
2	I HEREBY AUTHORIZE A WOMAN'S PLACE TO: { } OBTAIN FROM: { } RELEASE TO: _____ Facility or Physician's name _____ Facility or Physician's address Attention to: Telephone # Fax #
3	WILL YOU BE RETURNING TO A WOMAN'S PLACE FOR FUTURE CARE? { } YES { } NO IF YOU ARE LEAVING THE PRACTICE, SELECT ONE OF THE FOLLOWING REASONS YOU ARE LEAVING: { } Moving from area { } Change of insurance { } Unhappy with service { } Unhappy with quality of care { } Other _____
4	I WISH TO RELEASE/OBTAIN THE FOLLOWING MEDICAL INFORMATION: { } All Record Information { } History & Physical { } Lab Reports { } Progress Notes/Physician Notes { } Operative Reports { } Radiology Reports { } Pathology Reports { } Other _____ RECORDS REQUESTED FOR THIS SPECIFIC DATE RANGE: _____ IF MY RECORDS CONTAIN THE FOLLOWING PROTECTED HEALTH RECORDS, I DO NOT AUTHORIZE THE PRACTICE TO RELEASE THIS INFORMATION (If you have NO restrictions, please leave BLANK): { } Genetic testing { } Psychotherapy/Psychiatric/Mental Health { } Substance abuse information { } HIV/AIDS I UNDERSTAND THAT TREATMENT AND COVERAGE IS NOT BASED UPON MY SIGNING THIS AUTHORIZATION. THIS INFORMATION IS NEEDED FOR: { } Ongoing treatment/aftercare { } Request of the patient or parent/legal guardian { } Other _____
5	I understand this authorization is subject to revocation at any time unless action based on it has already begun. Requests for revocation will be done in writing. The authorization expires 90 days from the date of signature. I understand that the information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I further release the persons and/or agencies named above from any liability arising from the release of this information to such persons and/or agencies, provided the said release of information is done substantially in accordance with the applicable law. By signing this form, I agree that a copy of this form is valid as the original. Date _____ Signature of patient _____ If patient is under 18, signature require of parent or legal guardian, as listed in Release of Information: Signature of parent/guardian _____ Relationship to patient _____

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