Women's Care
consultants

## AUTHORIZATION For The Release of Medical Information

Patient Name: _____ Date of Birth: _____ Phone Number: _____

Patient Address: _____

_____

I hereby authorize Women's Care Consultant's to release my medical information to:

Name: _____ Attention to: _____

Address: _____

PHONE: _____ FAX: _____

☐ Entire Medical Record ☐ Partial Medical Record: Office Notes, Labs, X-Ray, Surgical Procedures Approximate Dates of Treatment: _____

Reason for Request ☐ Personal Use, ☐ Legal, ☐ Second Opinion, ☐ Change in health care provider ☐ Other _____

This authorization expires in 6 months from date of signed unless otherwise noted.

_____

I understand the following:

a. I may revoke this authorization at any time by providing written notice to the practice.
b. I may not be able to revoke this authorization if the practice has already taken action utilizing this authorization or if the authorization was obtained as a condition of obtaining insurance coverage.
c. I am signing this authorization freely and under no pressure from any individual to do so.
d. The information disclosed in this authorization may be subject to redisclosure by the practice and no longer protected by federal law.
e. I acknowledge that I have had an opportunity to review this authorization and understand the intent and use.
f. My medical records may contain genetic testing information including test results.
g. This authorization may include disclosure of information regarding HIV. The recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand I have the right to request a list of people who received or use my HIV-related information without authorization.

_____

Medical Records Copying Fees: $20.00 for the first page then $0.53 per page after.

_____

Patient Signature: _____ Date: _____

For a child: I hereby declare that I am the natural or adoptive parent or legal guardian of said child and there is no court order restricting or prohibiting my access to such medical records.

Signature or Patient's Representative: _____ Relationship: _____ Date: _____

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