



Authorization for Release of Medical Information

In accordance with legal and regulatory agency requirements, the health record is the property of Women Partners in Health. A fee of \$15 is charged for copying the records, and we will fulfill your request when the fee is paid.

I hereby authorize the release of information from the medical record of:

Patient Name _____ Date of Birth _____

SS# _____ Telephone # _____

Address _____

City _____ State _____ Zip _____

Information Released to:

Name _____ Telephone # _____

Address _____

City _____ State _____ Zip _____

Please release:

- | | | | |
|---|---|--|--------------------------------------|
| <input type="checkbox"/> All Records | <input type="checkbox"/> History & Physical | <input type="checkbox"/> X-Ray Reports | <input type="checkbox"/> ECG Reports |
| <input type="checkbox"/> Immunizations | <input type="checkbox"/> Mental Health | <input type="checkbox"/> Drug/Alcohol | <input type="checkbox"/> Lab Reports |
| <input type="checkbox"/> Operative Report | <input type="checkbox"/> Only the following _____ | | |

The information is necessary for the following purpose:

- | | | |
|--|--|---|
| <input type="checkbox"/> Changing physicians | <input type="checkbox"/> Personal Use | <input type="checkbox"/> Attorney/Legal |
| <input type="checkbox"/> Insurance | <input type="checkbox"/> Other (specify) _____ | |

Informed Consent for Release of Confidential Information:

I understand that:

- I may revoke this consent in writing at anytime except to the extent actions have already been taken.
- This consent will expire 180 days after the date of my signature unless otherwise specified.
- That there is a fee for copy services rendered.
- That the information may include HIV/AIDS, mental health and chemical dependency diagnosis, treatment and test results.
- That the information released is for the specific purpose stated above.
- That my medical records may contain reports only a physician can interpret.
- I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries.
- I will not hold Women Partners in Health liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.
- That the payment of the above fee is due prior to my record release and that within fifteen (15) days of receipt of payment, my records will be available.
- Women Partners in Health is required to comply with Federal HIPPA regulations concerning medical privacy, and that I may view the office policy at any time.

Signature of patient or legal representative _____

Date _____ Relationship to patient _____