

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 \$25 is charged for copying the records, and we will fulfill your request when the fee is paid. This form must be completed in its entirety in order for us to process your request.

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

Patient Name _____ Date of Birth _____

SS# _____ Telephone # _____

Address _____

City _____ State _____ Zip _____

<p>Information Released: TO FROM (<i>circle one</i>)</p> <p>Women Partners In Health 1305 W. 34th Street, Ste 308 Austin, TX 78705 Phone (512) 459-8082 Fax (512) 458-5446</p>	<p>Information Released: TO FROM (<i>circle one</i>)</p> <p>Name: _____ Address: _____ Phone: _____ Fax: _____</p>
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Please release:

- | | | | |
|---|---|---------------------------------------|---|
| <input type="checkbox"/> All records | <input type="checkbox"/> X-Ray Reports | <input type="checkbox"/> Lab Reports | <input type="checkbox"/> History & Physical |
| <input type="checkbox"/> HIV/AIDS Test | <input type="checkbox"/> Mental Health | <input type="checkbox"/> Drug/Alcohol | <input type="checkbox"/> Immunizations |
| <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 (<i>specify</i>) _____ | | | |

How would you like information released?

(*Circle one*) Mail Fax Pick up

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 _____