Consultants in Women's Healthcare, Inc.

David L. Weinstein, MD, FACOG
Jennifer H. Smith, MD, FACOG
Juliana C. Verticchio, MD, FACOG
Julia G. Hoffman, MD, FACOG
Kris A. Scalf, RNC, WHNP, MC
Savannah S. Hayes, RNC, WHNP-BC

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

For records being sent to another office/provider

Patient Identification

Name (Print) _____ **Date of Birth:** _____

Address _____ **Last four digits of SSN:** _____

_____ **Telephone:** _____

Name At Time of Treatment If Different: _____

Information To Be Released – Covering the Period of Health Care

From (date): _____ **To (date):** _____

From (physician): _____

Please check type of information to be released: □ **ALL RECORDS or as specified below:**

□ **History/Physical Exam** □ **Operative Note** □ **Discharge Summary** □ **Pathology Report**
□ **Pap Smear Results** □ **Lab Test Results** □ **Mammogram Reports** □ **DEXA or BMD Reports**
□ **Other (specify)** _____

Purpose of Request

□ **Treatment or Consultation** □ **Patient Relocation** □ **To Obtain Insurance** □ **At The Request of the Patient**
□ **Other (specify):** _____

Please send above information as indicated to the provider below:

Name: _____

Address: _____

Office Phone: _____ **Office Fax:** _____

Drug and/or Alcohol Abuse and/or Psychiatric and/or HIV/AIDS Records Release (PLEASE INITIAL BOTH STATEMENTS)

_____ **I understand that the information in my medical or billing record may include information relating to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, hepatitis B or C testing and/or other sensitive information.**

_____ **I understand that the information in my medical or billing record may include information relating to HIV/AIDS testing and/or treatment.**

Time Limit & Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, you have the right to revoke this authorization by submitting a notice in writing to the Department of HIS or other Department to whom you are authorizing disclosure. Unless revoked, this authorization will expire on the following date or event, _____, or 90 days for date of signature.

Re-disclosure

I understand the information disclosed by this authorization may be subject to unauthorized re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility of liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Person Representative Who may request Disclosure

I understand that I do not have to sign this authorization. I can inspect the protected health information to be used or disclosed.

_____ _____

Signature of Patient **Date**

_____

Signature of Legal Representative and Relationship to Patient

(medrecordrelease)