Premier Women's Health

Carolyn Kollar, DO FACOOG
1758 Broad Park Circle South
Mansfield, TX 76063
(972) 780-7330
Fax: (972) 780-7385

Authorization for Release of Information

Patient Name: _____
Previous Name: _____
Date of Birth: _____ Social Security #: _____

I understand and authorize my medical information to be released to Premier Women's Health from:

_____

_____

This information is to be released to:

Premier Women's Health
Dr. Carolyn Kollar
1758 Broad Park Circle South
Mansfield, TX 76063
Fax (972) 780-7385

I understand that the information is to be released for the following purposes:

_____ Treatment _____ Referral _____ Co-management

_____ Continuity of care _____ Record Review _____ Patient Request

_____ Other, please specify: _____

Information to be requested from following time period:

From: _____ (month/year) To: _____ (month/year)

I hereby authorize Premier Women's Health to use/disclose my protected health information in accordance with the current Health Insurance Portability and Accountability Act (HIPAA) guidelines. I understand that I may be responsible for any processing fee that may be required for the requested information. Identification will be required for patient privacy and confidentiality.
I understand that my medical information may include sensitive health information. I understand that I a may revoke this authorization in writing at any time. I understand that the authorization expires 180 days from the date of my signature. A photocopy of this authorization is considered as valid as the original. I understand that if the recipient authorized to receive the health information is not a health plan or health care provider the released information may no longer be protected by federal and state privacy regulations.

_____

Signature of Patient or Legal Representative Date/Time

_____

If Representative, specify relationship to patient Date/Time

If more than 10 pages please mail the records to our office