

# AUTHORIZATION TO RELEASE PATIENT MEDICAL INFORMATION PATIENT INFORMATION TO CAPITAL WOMEN'S CARE

Patient Name: \_\_\_\_\_\_ Acct.# \_\_\_\_\_

Former Name (if any)\_\_\_\_\_\_ SS. #\_\_\_\_\_

Daytime Telephone \_\_\_\_\_ Birth date \_\_\_\_/ \_\_\_/

# **INFORMATION TO BE RELEASED FROM:**

I hereby authorize \_\_\_\_\_\_\_ (NAME OF OTHER PROVIDER RELEASING INFORMATION) to use and disclose my individually identifiable Protected Health Information (PHI) in the manner described below. I understand that my PHI may be redisclosed by the person or entity receiving my PHI from the above named provider, and that it then may no longer be protected by federal privacy regulations. State law may or may not prohibit such redisclosure by the person or entity receiving my PHI from the above named provider. I voluntarily sign this authorization, and I understand that my health care will not be affected if I do not sign this form.

#### PROTECTED HEALTH INFORMATION TO BE RELEASED TO:

Name of Organization	Site Location:	Street Address	City/State/Zip
Capital Women's Care			

Purpose or need for this information is:

### **TYPE OF INFORMATION TO BE RELEASED: 1. GENERAL RELEASE:**

Type of Record

\_\_\_\_Medical Records/Excluding Protected Records

(This will be limited to 2 years of information including x-ray, Lab reports unless otherwise stated).

\_\_\_Lab Results (specify)\_\_\_\_\_

\_\_\_\_X-ray Reports (specify)\_\_\_\_\_\_

\_\_\_\_Surgical records (specify)\_\_\_\_\_

\_\_\_Other Records (specify)\_\_\_\_\_

# 2. INFORMATION PROTECTED BY STATE/FEDERAL LAW:

\_\_\_Drug Abuse Diagnosis/Treatment (specify) \_\_\_\_\_

Alcoholism Diagnosis/Treatment (specify)

\_\_\_\_Mental Health Diagnosis/Treatment (specify) \_\_\_\_\_

\_\_\_\_\_Sexually Transmitted Disease (specify)

X

Diagnosis/Treatment or Counseling (includes Aids/HIV) (specify)

I understand that I have the right to receive a copy of this authorization. I also understand this authorization is valid for 90 days only and may be revoked in writing at any time prior by notifying \_\_\_\_\_\_ (Name of Entity Releasing Information) in writing. I understand I have the right to revoke the authorization at any time except to the extent that action has been taken in reliance thereon.

# PATIENT AUTHORIZATION TO RELEASE MEDICAL INFORMATION