ADVANCED WOMEN'S HEALTH SPECIALISTS

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AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I, _____ hereby authorize Advanced Women's Health Specialists to release my medical, alcohol, drugs, and/or HIV, ARC and/or AIDS information contained in my records as indicated below:

Name of person	**Relationship**
1. _____ **(Last name, First name)**	_____
2. _____ **(Last name, First name)**	_____
3. _____ **(Last name, First name)**	_____

Purpose of Disclosure: _____

I understand that this consent is revocable upon written notice to the doctor, except to the extent that action by the doctor has been taken in reliance on this authorization, and this authorization shall remain force for a reasonable time _____, in order to effect the purpose for which it is given.
(Expiration Date)

Alcohol and drug abuse information, if present was disclosed from records whose confidentiality is protected by Federal Law. Federal regulations (42 CFR, Part II) prohibit, making any further disclosures of such information without a specific written authorization of the undersigned, or as otherwise permitted by such regulations.

HIV testing, ARC and/or AIDS diagnosis information, if present has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosures of such information without a specific written consent of the person to whom such information pertains or as otherwise permitted by state law. A general authorization for the release of medical or other information is NOT for this purpose.

_____	_____
Witness	Patient Signature
_____	_____
Date	Print Name