Center For Women's Health

Offices at Cranbrook ▪ 10111 East 21st Street North ▪ Suite 301 ▪ Wichita, KS 67206

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RECORDS RELEASE FORM

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize C**enter for Women's Health**

(**Circle One**):**Release My Records to:** **OR** **Get My Records From:**

Provider's Name:_____

Provider's Address:_____

Provider's Fax #:_____

Entire Record Lab Results Radiology Results

Office Notes OP Reports Other:_____

Purpose of Disclosure: ___Currently Pregnant? Other _____

Are you transferring care / why? _____

Copying Fees:*If you are requesting a copy of your medical record for yourself, instead of having it sent to another physician- there is an $18.97 labor fee, plus $0.63 per page for the first 250 pages, and $0.45 per page for additional pages. Physician to Physician is FREE.*

I understand that the information in my health record may include information relating to sexually transmitted disease, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the number above. I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to the facility checked above. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____**.** If I fail to specify an expiration date, event, or condition, this authorization will expire in six months. I understand that be given a copy of this authorization form, after signing. I understand that copying charges will be applied according to office policy.

_____ _____ _____

Signature of Patient or Legal Representative **Relationship to Patient** **Date**

_____ _____

Patient Name (Print) **Print Name of Patient/Representative**

_____ _____

Patient's Date of Birth **Patient's Social Security Number**