All Care For Women

Authorization for Use and/or Disclosure Of Protected Health Information

This form authorizes All Care for Women to use and/or disclose protected health information in the manner described below and is voluntary. All Care for Women will not condition treatment, payment, enrollment or eligibility for benefits on the execution of the Authorization. The information used or disclosed as a result of this Authorization may be subject to re-disclosure by the person or entity receiving such information, and no longer protected by the federal privacy regulations.

PATIENT INFORMATION

Patient name:____ Gender ☐ Male ☐ Female
Last First Middle Maiden (if applicable)

Street Address:_______________________ City/State:_______________ Zip: __________

Date of Birth_______________________ Phone: (   ) _______________________

Parent / Guardian / Requestor Completing Form: _______________________________

☐ **SEND MEDICAL RECORDS TO** ☐ **OBTAIN MEDICAL RECORDS FROM**

Name: ___________________________ Organization (if applicable) ___________________

Street Address____

City/State___________________________ Zip Code__________ Telephone____________

Information may be: ☒ Mailed ☒ Faxed ☐ Reviewed only ☐ Discussed via Telephone ☐ Picked up by: ________________

<u>MAIL RECORDS IF OVER 20 PAGES**</u>**

THERE IS A 75 CENT PER PAGE FEE FOR COPYING AND ADMINISTRATIVE COSTS*

PURPOSE

Records are to be released for the following purpose (s): (Select all that apply)

☐ Medical Care ☐ Attorney/Legal ☐ Personal ☐ Insurance ☐ Disability/SSI ☐ New Physician ☐ Consult/2nd opinion ☐ Moving ☐ To Primary

☐ Dissatisfied with Office/Service ☐ Other: ___________________________

INFORMATION TO RELEASE

Dates of Treatment/Particular Illness Requested: ______________________________

☒ **LAST** Office Notes ☒ **LAST** Physical ☒ **RECENT** X-ray/Mammograms/ Ultrasounds ☒ **RECENT** Obstetrics & Labs ☒ LAST 3 Pap smears

☒ Other _**<u>SURGICAL OPERATIVE & PATHOLOGY REPORTS</u>**_______________________

PATIENT/PARENT/LEGAL GUARDIAN AUTHORIZATION

Unless otherwise revoked, this Authorization will expire one (1) year from the date it is signed or, if signed or, if specified, on the following date, event or condition (complete if desired): ______________. This Authorization may be revoked at any time. However, the revocation will not apply to uses or disclosures occurring prior to our receipt of your revocation request. In order to evoke the Authorization the individual/parent/legal guardian must submit a revocation request in writing to the Health Information Management department at the address below. Please refer to All Care for Women's Notice of Privacy Practices. If All Care for Women requests this Authorization for its own use or disclosure, a copy of this Authorization must be provided to the individual completing this form.

I, the undersigned, hereby authorized All Care for Women to use and/or disclose information from my (or give relationship) ______________ medical or financial record as specified above.

Signature of Patient:_________________________________ Date:________________

Signature of: ☐ Parent/ ☐ Legal Guardian (check one):

_________________________________Date:________________

Note (If Legal Guardian box is checked, documentation establishing guardianship must be provided or on record in order to comply with above request.

SUBMIT TO

Please verify that all sections are completed in full. Upon completion, please send the form to:

All Care For Women **Fax the form to: (716) 688-6716**

6095 Transit Road **East Amherst, NY 14051** **(716)-634-9303**	OR