The Women's Center

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*****You can submit your request via your patient portal @ wcorlando.com*****

Authorization for Release and Use of Protected Health Information under HIPPA

Patient Name _____ SS# _____

Contact Number _____ Date of Birth _____

I: The undersigned patient, named above, hereby executes this authorization in compliance with the Health Insurance Portability and Accountability Act, HIPPA, 45 cfr. 104, and requests that the following health care provider (including its agents, employees and associates) release his or her records:

Release Records From: _____

Phone number: _____ Fax number: _____

II: The above-named provider is requested to release the protected health information (PHI) that is described below to:

Release Records To: _____

Phone number: _____ Fax number: _____

Records are to be: _____ Picked up _____ Faxed ____ Mailed

III: The protected health information released herein is specifically as follows:

____All records ____ All diagnostic test results ___Alcohol/Drug Abuse Treatment ____Sexual Transmitted Diseases
____ HIV/AIDS-related treatment ____Psychotherapy Notes ONLY ____Mental Health____ Other/ Specific:_____
____ Only the period of Events from: _____ to _____

IV. Purpose of Disclosure: ____ Further Medical Care ____ Attorney ____School ____Research
____Personal Use ____Insurance ____Disability ____Health Information Exchange ____Others _____

- This authorization may be revoked at any time by a signed and properly dated written revocation to the specific health care physician being provided within this request. This release cannot be revoked as to protected health information that had been previously released in reliance on this document.
- I understand that I am under no obligation to sign this document and that my ability to obtain treatment will not depend in any way on whether I sign this authorization.
- I understand that once the PHI is disclosed, it may be re-disclosed to individuals or organizations that are not subject to the federal privacy regulation. The Women's Center cannot guarantee that the recipient of the information will not re-disclose this information.
- A photocopy of this authorization shall be considered as effective and valid as the original and this authorization will expire ninety (90) days after the date executed, unless earlier revoked.

_____ _____ _____

Patient's signature/Legal representative signature Print Name Date

*****Medical records request fee $1.00 per page up to 25 pages*****

***** Medical records can take up to 72 hours to be processed *****