General Medical Records Release and Authorization for Use or Disclosure of Protected Health Information- Life Care For Women

Please complete the following information:

Patient Name: _____

Address: _____

_____

Phone: _____

SSN: _____Date of Birth:_____/_____/_____

I authorize the custodian of records of: this entity _____
to disclose/release the following information* (check all applicable):

- ☐ All records
- ☐ Laboratory/pathology records
- ☐ X-ray/radiology records
- ☐ Billing records
- ☐ Abstract/Summary
- ☐ Pharmacy/prescription records
- ☐ Other (describe specifically)

***Note:** If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.*

These records are for services provided on the following date(s): _____

Please send the records listed above to (use additional sheets if necessary):

Name: _____

Address:_____

_____

Phone_____

Fax:_____

Name: _____

Address: _____

_____

Phone _____

Fax:_____

The information may be used/disclosed for each of the following purposes:

- ☐ At my request (only the patient can check this box)
- ☐ For my health care
- ☐ For payment/insurance
- ☐ For employment purposes
- ☐ Other:

This authorization shall expire no later than: ___/___/___ or upon the following event _____
(whichever is sooner), and may not be valid for greater than one year from the date of signature for

.

_____ _____

Signature of patient or personal representative Date

_____ _____

Printed name of patient representative Representative's authority to sign for patient, *(i.e., parent ,guardian)*