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Women's Health INSTITUTE

RELEASE FROM

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

CONSENT for USE or DISCLOSURE of PATIENT INFORMATION for the PURPOSES of TREATMENT, PAYMENT and HEALTHCARE OPERATIONS

Patient Name _____Date of Birth_____

I hereby consent to Women's Health Institute, LTD (the "Practice") using or disclosing my protected health information for the purpose of providing treatment to me, obtaining payment for health care services rendered to me or to carry out the Practice's healthcare operations. I also consent to Practice using or disclosing my protected health information to treatment activities provided by another health care provider, as well as the payment activities conducted by another health care provider or health care entity to conduct health care operations including quality assessment and reviewing the competence of health care professionals.

Specific Records Expressly Included. I expressly authorize release of the following information for the purposes of treatment, payment and healthcare operations, it is part of my protected health information (CHECK ANY OR ALL YOU AGREE TO AUTHORIZE FOR RELEASE):

( ) All Patient Records ( ) History & Physical ( ) X-Ray Reports ( ) Discharge Summary
( ) Laboratory Results ( ) Progress Notes ( ) HIV Test/Status ( ) Other _____
( ) Chemical Dependence/Substance Abuse/Drugs/Alcohol ( ) Sexually Transmitted Diseases

Information Release Requested By:
Patient: _____ SS#: _____

Street Address: _____
City/State/Zip: _____ Phone: _____

Above records to be released to:
Provider/Facility: _____Fax:_____

Address: _____
City/State/Zip: _____ **Phone: _____**
These records are requested for the following reason:
( ) Continued Medical Care ( ) New OB/GYN Provider ( ) Other_____

I further acknowledge the Practice has provided me a copy of its Notice of Privacy Practices, which provides a detailed description of the use and disclosures allowed by this consent, as well as other rights I have regarding my protected health information.

_____ Signature of Patient or Personal Representative

_____ Date

_____ Signature of Witness

_____ Restrictions to Dates/Episodes