CAPITAL WOMEN'S CARE

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# AUTHORIZATION TO RELEASE PATIENT MEDICAL INFORMATION

## PATIENT INFORMATION

Patient Name _____ Acct # _____

Former Name (if applicable) _____ SS # _____

Daytime Telephone # _____ Date of Birth ___/____/_____

## INFORMATION TO BE RELEASED FROM

I hereby authorize Capital Women's Care (CWC) to use and disclose my individually identifiable Protected Health Information (PHI) in the manner described below. I understand that my PHI may be redisclosed by the person or entity receiving my PHI from CWC, and that it then may no longer be protected by federal privacy regulations. State law may or may not prohibit such redisclosure by the person or entity receiving my PHI from CWC. I voluntarily sign this authorization, and I understand that my health care will not be affected if I do not sign this form. I understand that CWC reserves the right, according to their HIPAA Practicing Guidelines, to use a third party vendor (Universata or Smart Corporation) to process/copy medical records containing PHI information. Not all CWC's practices use this method for copying records release.

## PROTECTED HEALTH INFORMATION TO BE RELEASED TO

_____ Name of Organization

_____ Street Address

_____ City, State, Zip Code

Purpose or need for this information is _____

## TYPE OF INFORMATION TO BE RELEASED

***General Release***

Type of Record to be Released (please check all that apply)

- ◯ Medical Records/Excluding Protected Records *(Limited to 2 years of info, including X-rays and Lab Reports, unless noted)*
- ◯ Lab Results (specify) _____
- ◯ X-ray Reports (specify) _____
- ◯ Surgical Records (specify) _____
- ◯ Other Records (specify) _____

***Information Protected by State/Federal Laws***

- ◯ Drug Abuse Diagnosis/Treatment (specify) _____
- ◯ Alcoholism Diagnosis/Treatment (specify) _____
- ◯ Mental Health Diagnosis/Treatment (specify) _____
- ◯ Sexually Transmitted Disease (specify) _____
- ◯ Diagnosis/Treatment or Counseling (includes AIDS/HIV) (specify) _____

I understand that I have the right to receive a copy of this authorization. I also understand this authorization is valid for 90 days only and may be revoked in writing at any time prior by notifying CWC in writing. I understand I have the right to revoke the authorization at any time except to the extent that action has been taken in reliance thereon.

## PATIENT AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I certify that I have read, signed and received a copy of this authorization upon my request. I understand I will be billed for copies of my medical record according to HIPAA State of Maryland and Federal laws.

_____ Date

_____ Signature of Patient/Legally Responsible Party

_____ Relationship to Patient

**CWC USE ONLY**

Total Fee _____ Internal Processing _____ External Processing _____

Date Request Received _____ Date Mailed/Faxed/Picked up from Office by Patient _____