Total Women's Care, Inc.
1445 Harrison Ave NW, Suite 302
Canton, Ohio 44708
Phone (330) 452-9900
Fax (330) 452-9945

Authorization for Release of Protected Health Information

I, _____ (print patient name) ____/____/____ (birthdate), ____-____-____ (Social Security No.) authorize

Total Women's Care, Inc. ("TWC"), to [ ] disclose to, or [ ] request from the following person/entity, the protected health information described below in accordance with this authorization:

_____
(Name of other person or organization)

_____
(Street Address)

_____
(City, State, Zip)

By: [ ] Mail
[ ] Fax at: _____
[ ] Will pick up on: _____
[ ] Electronic Format: _____
[ ] Other: _____

PROTECTED HEALTH INFORMATION TO BE RELEASED:
[ ] All information in my record from (date) _____ to _____.
[ ] All information related to _____
_____.
[ ] In addition, please release lab results related to the above.

PLEASE INITIAL ONE OF THE FOLLOWING:
_____ I consent to the release of any information pertaining to alcohol or drug abuse, psychiatric condition, any condition related to sexually transmitted disease and/or HIV (Human Immunodeficiency Virus) and AIDS (Acquired Immune Deficiency Syndrome).

_____ I do not consent to the release of any information pertaining to alcohol or drug abuse, Psychiatric condition, any condition related to sexually transmitted disease and/or HIV (Human Immunodeficiency Virus) and AIDS (Acquired Immune Deficiency Syndrome).

FOR THE PURPOSE OF: [ ] Continued Care [ ] Personal Use [ ] Other _____

1.) This consent will be valid for 1 year (365 days) from the date of signing unless otherwise stated. My permission is extended only for the purpose as stated on this authorization.
2.) I understand that I have the right to revoke this authorization at any time by sending a written notification to Total Women's Care, Inc. 1445 Harrison Ave NW, Ste 302, Canton, Ohio 44708. I understand that the revocation will not apply to information that has already been released in response to this authorization.
3.) I understand that information used or disclosed carries with it potential risk for an unauthorized re-disclosure and the information may no longer be protected by federal privacy rules.
4.) Total Women's Care, Inc. will not condition my treatment on whether I provide authorization for the requested use or disclosure.
5.) I understand that I may request a copy of this authorization.
6.) I understand that I will be responsible for any charges incurred for the copying or mailing of my file.

_____ _____
(Signature of Patient/Legal Guardian + relationship) (Date)