Woman's Health Centers

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____ Date: _____
Address: _____ SS#: _____
_____ D.O.B: _____

Receive Records **FROM**: Release records **TO**:

_____ _____
_____ _____
_____ _____

Please send a copy of my records as indicated for date(s) of treatment:_____

_____Operative Records _____ Discharge Summary

_____ Prenatal Records _____ History & Physical _____ Other:_____

_____ Lab Results _____ Radiology Reports

Purpose for releasing medical information:_____

- ☐ I authorize the release of my STD HIV/AIDS testing to the person(s) listed above.
- ☐ I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

I understand that my express consent is required to release any health information relating to testing, diagnosis and/or treatment of alcohol or drug related medical problems. This special consent also will apply to HIV/AIDS, related diagnosis, sexually transmitted diseases and psychiatric disorders/mental health. This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42C.F.R Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person whom it pertains of as otherwise permitted by such regulations. This authorization can be revoked but not retroactive to the release of information made in good faith.

_____ _____ _____
Signature of Patient / Legal Rep. Witness Date