Women's HEALTH CENTER OF CLARKSVILLE

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AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

REQUEST RECORDS FROM:

Person or facility releasing your records: _____

Phone / Fax (please circle which): _____

I hereby authorize the disclosure of the following protected health information from the medical records of the patient listed below. I understand that information used or disclosed by this authorization may be subject to re-disclosure by the recipient and may not be subject to federal or state law protecting this confidentiality.

Patient Name (print): _____

Date of birth (mm/dd/yyyy): _____-_____-_____ Social Security #: _____-_____-_____

Address: _____

Street City State Zip code

SEND RECORDS TO: (Please mail records if more than 20 pages)

Information to be disclosed to (person or facility receiving records):

Name/Facility: _____

Phone/Fax: _____

Address: _____

*I understand there may be a fee for obtaining a copy of my **personal** medical information indicated below:

Reason for Medical Release **(CHOOSE ONE):**

Selecting New OBGYN (Transferring Care): _____ Send to Primary Care Physician: _____

Relocating Out of Town: _____ Personal: _____ ($20.00 fee must be paid at time of request)

Disclose the following information for treatment dates (**if you are unsure, please ask**): _____ to present.

Labs: _____ Last Pap: _____ Last Mammogram: _____ Ultrasounds: _____

Operative Reports: _____ Summary Report _____ Other as specified: _____

I direct that all information obtained with this release be held in strict confidence by the recipient and further direct that it is not to be further disclosed without my specific written authorization. I understand that this authorization shall remain in effect for sixty (60) days from the date of my signature below unless I specify an earlier expiration date in this space: _____. I understand that except to the extent that action has been taken based on my authorization, I may withdraw this authorization at any time by written notification to the parties involved. I am also releasing information specified above containing treatment for drug and/or alcohol abuse, for psychiatric and/or mental conditions, or HIV test results (if applicable) or diagnosis. I am including this type of information to be release in association with this authorization.

Patient Signature: _____ Date: _____

(For Office Use) Witness: _____ Date: _____