Partners for Women's Health, PA

meeting the changing health needs of women

AUTHORIZATION TO RELEASE MEDICAL RECORDS

As required by the Health Insurance Portability and Accountability Act of 1996(HIPPA), this practice may not use or disclose your individually identifiable health information without your authorization except as provided in our Notice of Privacy Practices. Your completion of this form means that you are giving permission for the uses and disclosure described below. Please review and complete this form carefully. It may be invalid if not fully completed. You may wish to ask the person or entity you want to receive your information to complete the sections detailing the information to be relaxed and the purposes for the disclosure.

PATIENT NAME:_____ DOB:_____

ADDRESS:_____

PHONE #:_____ ALT #:_____

PLEASE OBTAIN INFORMATION FROM:

_____
Name of Provider/Clinic/Organization

_____
Street Address

_____
City, State, Zip

_____ _____
Phone Fax

PLEASE SEND INFORMATION TO:

_____
Name of Provider/Clinic/Organization

_____
Street Address

_____
City, State, Zip

_____ _____
Phone Fax

I AUTHORIZE the following information to be disclosed: (if **Entire Record** is checked, all sensitive material **will be sent,** such as HIV, STD, mental health, and alcohol/substance abuse **unless initialed below**)
_____Entire Record _____Date(s) Only_____

Initial if you do not want these records included: _____ HIV _____STD _____Psychiatric/Mental Health
_____ Alcohol/Substance Abuse

REASON for disclosure of health information: (please **initial** reason for release – **must** be indicated on form)
_____New Primary Care Physician _____Transfer from practice _____Moved out of area _____2nd opinion
_____ Copy for myself; staying with practice

NOTE: If these records contain any information from previous providers or information about HIV/AIDS status, cancer, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.

EXPIRATION of this Authorization (please initial **ONE**) _____1 year after signature date _____ On this date_____

I am the: (please **check** one)
_____Patient _____Parent/Guardian _____ Person/Entity (describe specifically)_____

_____ _____
Signature of Patient (or Parent/Guardian, or Person/Entity) Date

_____
Printed Name of Patient (or Parent/Guardian, or Person/Entity)

Refusal to Sign Authorization
I understand that my health care treatment or benefits will not be affected whether I sign or do not sign this form. I understand that I may revoke this authorization at any time by notifying this medical practice in writing as described in the Notice of Privacy Practices. My revocation will not affect actions taken by this medical practice prior to its receipt. I understand that, if the recipient of the information is not a health care provider or plan covered by HIPPA, the information used or disclosed or described above may be re-disclosed by the recipient and no longer practiced by HIPPA. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV and AIDS-related information, and psychiatric/mental health information.

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