



WOMEN'S HEALTH CARE

Dr. Susan Catt, OB/GYN

Lindsey Fritz, APN

Carolyn Calhoun, CNM

Heather Porto, CNM

AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION

Patient Name: _____ Phone No.: _____

Patient Address: _____

Date of Birth: _____ Medical Chart No.: _____

- Purpose of copying records:**
- Transfer of care
 - Referral to specialist
 - Other: _____

Reason for Transfer: _____

I authorize *Affinity Women's Health Care* to:

(Please circle one) release information to / obtain information from:

Practice Name: _____

Practice Address: _____
Street City State Zip

Practice Phone No.: _____ Practice Fax No.: _____

Information to be disclosed:

- History & Physical
- Progress Notes
- Labs
- X-Rays/Imaging
- Operative Reports
- Other: _____

HIGHLY CONFIDENTIAL information to be disclosed:

- HIV/AIDS related health information
- Behavioral or mental health information
- Drug/Alcohol diagnosis, treatment, referral information
- Genetic testing information

I understand:

- ❖ That I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. In the event I refuse to authorize the release of the above-described information, I understand that it will not be disclosed, except as provided by law.
- ❖ That the practice may not condition treatment on whether I sign this authorization, except when the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.
- ❖ That information used or disclosed pursuant to this authorization may subject to redisclosure by the recipient and may no longer be protected by law.
- ❖ That this authorization is valid until it expires, unless revoked before the date provided.
- ❖ That I may revoke this authorization at any time by giving a dated written notice of my desire to do so to the physician. I also understand that I will not be able to revoke this authorization in cases where the physician has already relied on it to use or disclose my health information. A dated written revocation must be sent to the physician's office.
- ❖ That I have read and understand the terms of the authorization and I have had the opportunity to ask questions about the use and disclosure(s) of my health information.
- ❖ There is a copy fee of \$25.

By signing below, I knowingly and voluntarily authorize the disclosure of my protected health information as described above.

X _____ /_____/_____
Printed Name of Patient, Legal Guardian, or Authorized Agent Date

X _____
Signature of Patient, Legal Guardian, or Authorized Agent

Relationship to Patient

X _____
Witness Signature