Comprehensive Women's Care

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Full Name: _____

Date of Birth: _____/_____/_____ SSN ending: _____ (last four digits)

Patient Address:_____

I, _____, hereby authorize Comprehensive Women's Care, Inc.to disclose the following protected health information from my medical record:

☐ 1) My entire medical record including, any and all information pertaining to illness or injuries for which you examined and treated, including, but not limited to, progress notes, ER records, physical therapy notes, face sheet, history and physicals, consults, discharge summary, operative reports, pathology reports, radiology reports and x-ray films, lab reports, nursing records, physician orders, patient communications, copies of my records from other providers and/or facilities, records on sexually transmitted diseases, AIDS or AIDS-related conditions, HIV test results, treatment records for drug or alcohol abuse, and records pertaining to behavioral or mental health services such as medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: Diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date that may be contained in your files. **This authorization is not valid for any release of psychotherapy notes or records.**

☐ 2) My itemized statements and billing records.

☐ 3) My medical records as defined in part 1) but limited to the treatment dates from _____ to _____.

☐ 4) Only the specific information listed below:

_____

_____

To Whom the Records are to be Released:

Authorized to disclose the above designated protected health information to the following person or entity:

_____

_____

The purpose for the use or disclosure: _____

This authorization expires on the following date or event: _____ or 60 days after date of the signing of this authorization.

I understand that this Authorization is voluntary and that I have the right to revoke this Authorization at any time by delivering a written notice of revocation to the Privacy Officer of Comprehensive Women's Care, Inc. I understand that the revocation will have no effect on uses or disclosures that were made in reliance upon this Authorization prior to receiving the written notice of revocation. A photostatic copy shall have the same authority as the original and may be used in place of the original.

I understand that Comprehensive Women's Care, Inc. will not condition treatment, payment, enrollment or eligibility for benefits on whether or not I sign this Authorization. I also understand that once my information is disclosed under the terms of this Authorization, my information then may be re-disclosed by the recipient and no longer protected under federal or state privacy laws.

_____ Date: _____

Signature of the Patient or Legal Representative

If signed by Legal Representative, provide a description
of Legal Representative's Authority to sign on behalf of Patient