THE WOMEN'S PRACTICE

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Authorization for Release of Confidential Health Information

I, _____(DOB)_____, hereby authorize The Women's Practice, LLC to release to:

_____

_____

the following information contained in the patient record.

¨ The entire medical record, excluding mental health treatment, alcoholism treatment, drug abuse treatment, and HIV/acquired immune deficiency syndrome (AIDS) records.

To be disclosed, the following items must specifically by checked:

¨ Mental Health Treatment Records

¨ Alcoholism Treatment Records

¨ Drug Abuse Treatment Records

¨ HIV/Acquired Immune Deficiency Syndrome (AIDS) Records

¨ Laboratory Reports

¨ X-ray Reports

¨ Operative Notes

¨ Other:_____

The above information for the following period of time shall be released:

From: _____ to:_____

The purpose(s) of the authorization is (are)

_____

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.

I understand 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.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected under law.

I understand that this authorization is valid until it expires, unless revoked before that.

I understand that I may revoke this authorization at any time by giving written notice to the physician of my desire to do so. I also understand that I will not be able to revoke this in cases where the physician has already relied on it to use or disclose my health information. Written revocation must be sent to the physician's office. Absent such written revocation, this Authorization for Release of Confidential Health Information will terminate on _____.

Signed_____

Date:_____