Associates in Women's Health Care
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Authorization to use or disclose protected health information

I hereby authorize use or disclosure of the named individual's health information as described below:

Patient name:	Date of Birth:	Social Security Number:
Address: (street, city, zip code)		Telephone Number:

SEND MEDICAL RECORDS **[ ] TO** **[ ] FROM**

Associates In Women's Health Care

5 Medical Plaza Drive, Suite 250

Phone 916-782-2229 Fax 916-782-6909

SEND MEDICAL RECORDS **[ ] TO** **[ ] FROM**

Physician/Clinic: _____

Address: _____

Phone Number: _____ **Fax Number:** _____

Reason: [ ] Change of Insurance [ ] Personal [ ] Transfer of care
[ ] Moving out of area [ ] Legal [ ] Specialist consultation

The following information is to be disclosed: (Please check one box for each item)

Yes	No		Yes	No	
☐	☐	physician notes	☐	☐	lab results
☐	☐	x-ray reports	☐	☐	complete record
☐	☐	other _____			

Sensitive information: I understand that the information in my record may include information relating to sexually transmitted diseases, Acquired Immunodeficiency Syndrome (AIDS), or infection with Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

Redisclosure: I understand that any disclosure of information carries with it the potential for redisclosure and that the information then may not be protected by federal confidentiality rules.

Right to revoke: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and I understand that the revocation will not apply to information already released based on this authorization.

Other rights: (a) I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied. (b) I understand that I may inspect or obtain a copy of information to be used or disclosed.

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event, or condition: (If I do not specify an expiration date, event, or condition, this authorization will expire in six months)

_____ _____

Signature of patient or legal representative Date

unless otherwise stated, the fee for processing the release of medical records is as follows

1-12 pages $15.00 and 13-25 pages $25 (applies to records going directly to patient)

_____

If signed by legal representative, relationship to patient: