



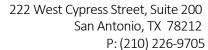
AUTHORIZATION FOR RELEASE OF INFORMATION

I understand that my provider is authorized by me to use or disclose my Protected Health Information for a purpose (described in this document) other than treatment, payment, or health care operations. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipient(s) of that information. I understand that treatment, payment, enrollment, or eligibility for benefits may not be conditioned upon me signing this authorization.

I specifically authorize my provider or its designated employee(s) to disclose my Protected Health Information as described on this form to the recipients listed below. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by state or federal privacy regulations. I further understand that I retain the right to revoke this authorization, if done according to the steps set forth below.

1. De	escription of the in	formation to be used or disc	closed (check as approp	oriate):			
	a. My entire record: (Please NOTE: If you check "my entire record," please SKIP to number 2. Otherwise, please continue with b. and c. below.						
							I understand that checking the box for "my entire record" authorizes the use or disclosure of all information in
	my medical record including, but not limited to: demographic information, patient histories, medication lists						
	tests, and diagnoses. I understand that my medical record may contain sensitive information. I specifically						
	authorize the use or disclosure of any information in my medical record related to (check all that apply):						
	□ Alcohol and Drug Abuse Treatment*						
	☐ HIV/Acquired Immune Deficiency Syndrome (AIDS)						
	 □ Mental and Behavioral Health (other than psychotherapy notes) and Developmental Disability Treatment □ Genetic Information (including, but not limited to, Genetic Test Results). 						
			,	•	•		
		aphic information (cheek "Al			0.1		
	□ All □ Name	□ Age □ Address	□ Gender□ State/Zip Code	□ Race□ Telephone	□ Other		
			• •				
	c. Medical Data /Information as related to (check all that apply):						
	□ Specific condition(s):						
	□ Specific professional service(s): □ Specific medication(s):						
	□ Alcohol and Drug Abuse Treatment:*						
	☐ Mental and Behavioral Health (other than psychotherapy notes) and Developmental Disability						
	Treatment:						
	☐ HIV/Acquired Immune Deficiency Syndrome (AIDS):						
	☐ Genetic Information including, but not limited to, Genetic Test Results:						
	□ Other:						
	Please disclose the above information FROM: Send TO:						
	Name/Entity:			Name/Entity:			
				Address:			
	Phone:		Phone:	Phone:			

Fax:





OBSTETRICS + GYNECOLOGY

1.	I [] Do [] Do Not authorize this information to be	e disclo	sed electronically.
2.	Purpose(s) for disclosure of the information:		
3.	reliance on this authorization. In order for the revocation in writing, and the revocation must include a. My name and address	ation of e: the recip orizationite 200,	
	ALL revocations must be sent to Women's Healt	th Instit	cute and are not effective until received by the business office.
5. Lui acc pa	Health Information for the above purposes without I fully understand and accept the terms of this authorises and that a reasonable amount of time (not to excording to TMA guidelines. The maximum fee will be \$	first ob orizatio cceed 1 525.00 f to the	on. 5 days) maybe needed to fulfill this request. A fee maybe charged for the first 25 pages, and \$0.25 for each additional page after 25 patient). There will be No Charge if records are sent directly to
	ignature of Patient or Patient's epresentative		Date
N	ame of Patient		Date of Birth of Patient
N	ame of Representative (if applicable)		Description of Representatives authority to act for patient

*CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS

This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 C.F.R. Part 2). The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general Authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.