Women's Health Alliance

Total Care, Total Trust... For Life

www.womenshealthalliance.com

Authorization / Consent for Release of Medical Information

Patient Name: ______________________ Date of Birth: ______________________

Last four of SSN: ______________________ Phone Number: ______________________

I hereby authorize:

Name: ______________________ Address: ______________________

City: ______________________ State: __________ Zip: __________

Phone: ______________________ Fax: ______________________

To release the following information:

❑ Progress Notes

❑ Radiology/Labs ______________________

❑ Prenatal Records

❑ Surgery Notes ______________________

❑ Complete Medical Record (includes information regarding insurance, demographics, referral documents and records.)

Information is to be released to:

Name: ______________________ Address: ______________________

City: ______________________ State: __________ Zip: __________

Phone: ______________________ Fax: ______________________

Purpose of disclosure (circle one): Treatment Payment Health Care Operations Transfer (please state reason) Other (specify below)

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I understand that I may revoke this consent/authorization at any time by notifying Women's Health Alliance® in writing. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my health information has acted in reliance upon this authorization.

THIS AUTHORIZATION WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING.

The facility, its employees and officers, and attending physician are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

I understand that according to applicable state and/or federal laws (Texas Medical Practice Act or Health Insurance Portability and Accountability Act), a re-disclosure could be made of records received from another physician or other health care provider involved in my care or treatment. I also understand the fee for preparing and furnishing medical records is $25.00 per 100 pages. Medical records will not be copied until payment is received; It may take up to 10 days to process the medical records.

Signature: ______________________ Date: ______________________

Patient or Legal Representative