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Authorization of Release of Individually Identifiable Protected Health Information

Patient Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip code: _____

Phone: _____ Social Security Number: _____

Request Records From: _____

physician or facility FROM whom you wish records to be sent

Address _____

Phone _____ Fax _____

I authorize the release of the above named person's health information to the Center for Women's Surgery as described below. Please forward this information to the address/fax printed on the top of this form. This information will be used for the purpose of diagnosis and treatment of a medical condition.

Please release the following medical information corresponding to the dates: _____

- Ultrasound, CT or MRI exams of the pelvis
• Lab tests (blood count, hormones or labs related to medical illness)
• Operative reports related to previous pelvic surgery
• Office notes from other providers relating to previous evaluation or treatment of the condition
• Other: _____

I authorize the following information to be included:

- Sexually transmitted diseases (STDs) _____ (initial here)
• Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) _____ (initials)
• Developmental disabilities, behavioral or mental health condition _____ (initials)
• Drug and alcohol treatment _____ (initials)

I understand that I have the right to revoke this authorization at any time by notifying the facility or physician that is authorized to make the disclosure, in writing, except to the extent that action has been taken in reliance on this authorization; or if this authorization is obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest the claim or the policy itself. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____ If no expiration date is specified, this authorization will expire in one year. I understand that this authorization of disclosure of health information is voluntary. I can refuse to sign this authorization, and I need not sign this authorization to receive treatment.

Signature of patient or patient's representative

Date

Relationship to patient