Southcoast Woman's Care

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name**:** _____ Date of Birth**:** _____

Address: _____

Phone Number: _____

RELEASE RECORD FROM:

Physician/Facility Name: _____

Address: _____

Phone: _____ Fax: _____

RELEASE RECORDS TO:

Physician/Facility Name: _____

Address: _____

Phone: _____ Fax: _____

INFORMATION TO BE RELEASED:

☐ All Records ☐ Records From _____ to _____

☐ Other: _____

FOR THE PURPOSE OF:

☐ Transfer of Care ☐ Second Opinion ☐ Continuity of Care ☐ Legal ☐ Insurance ☐ Other: _____

This authorization is valid for one (1) year. I understand I may revoke this authorization at any time by requesting such from Southcoast Woman's Care in writing, unless it has already been acted upon.

_____ _____
Signature of Patient/Guardian/Legal Representative Date

_____ _____
Printed Name of Guardian/Legal Representative Relationship to Patient

_____

I am aware my record may contain the following and I authorize the release of this protected health information:

☐ Mental Illness ☐ AIDS/HIV Information/Results ☐ Genetic Testing ☐ Drug/Alcohol Use or Test Results

☐ Sexual or Physical Abuse ☐ Sexually Transmitted Disease

_____ _____
Signature of Patient/Guardian/Legal Representative Date

_____ _____
Printed Name of Guardian/Legal Representative Relationship to Patient