A Woman's View

Authorization for the Release of Medical Information

Patient Name: ____
(Please Print) Last First Middle Maiden

Date of Birth: ____________________ Social Security #: ____________________

I hereby authorize A Woman's View to **provide/receive** a copy of my medical records **to/from**:
(Circle One) (Circle One)

____
Name

____
Address

____
City, State, Zip Code

____________________ ____________________
Telephone Fax

The purpose of the use or disclosure is: ____

____

Time period for medical records that are being released: From: ____________ To: ____________

The patient or the patient's representative must read and initial the following statements:

I understand that this authorization will expire on ____________________ Initials ____________

I understand that I may revoke this authorization at any time by notifying A Woman's View, P.A. in writing, but if I do it will not have an effect on any actions taken in reliance on my authorization before the practice received the revocation. Initials ____________

NOTICE TO PATIENTS: The patient or the patient's representative may inspect and/or copy the health information to be used or disclosed in accordance with A Woman's View policies. **You may refuse to sign this authorization**. A Woman's View, P.A. will not condition treatment or payment on your providing this authorization except in the specific circumstances allowed by the Privacy Rule.

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that when the information is used or disclosed, it may be subject to being redisclosed and may no longer be protected by federal privacy regulations.

Patient Name: ______________________________ Birth Date: ____________________
(Please Print)
Signature: ______________________________ Today's Date: ____________________

Printed name of patient's representative, if applicable ______________________________

Representative's Authority: ______________________________