

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

(Please print)

Patient Name: _____

Last Four Digits of Social Security _____

Address: _____

Patient Date of Birth: ____/____/____

Patient Phone No.: _____-_____-_____

Release Authorization: (Please print)

Patient GW/EHR ID _____

I _____ hereby authorize Seven Hills Women's Health Centers to release medical records in its possession, including information regarding my medical condition and treatments I have received. I understand the records to be released may include information regarding sexually transmitted diseases, drug or alcohol abuse, HIV/AIDS testing and status, and psychiatric condition.

_____ Release medical records for date(s) of service ____/____/____ to ____/____/____.

_____ Release copy of complete medical record

_____ Release only those records for items checked below:

history and physical for date(s) of service ____/____/____ to ____/____/____.

cytology reports for date(s) of service ____/____/____ to ____/____/____.

operative notes for date(s) of service ____/____/____ to ____/____/____.

pathology reports for date(s) of service ____/____/____ to ____/____/____.

discharge summary regarding _____ on ____/____/____.

_____ Release other specific medical record information.

Specify: _____

To Whom the Records are to be Released:

Seven Hills Women's Health Centers is authorized to disclose the above designated protected health information to the following person or entity:

_____ Records are to be mailed to: Name of Recipient: _____

Recipient Address: _____

_____ Records are to be picked up by me, the patient, or legal patient representative. (Photo ID must be presented at this time)

Purpose of Use or Disclosure:

Purpose or reason for the use and/or disclosure of the information requested: _____

Expiration Date of Authorization: The authorization will automatically expire one (1) year from the date of signature. We will not honor requests for disclosure after expiration without an updated authorization form. You may renew or alter this authorization form at any time.

Right to Terminate or Revoke Authorization: You may revoke or terminate this authorization by submitting a written revocation to Seven Hills Women's Health Centers Medical Records Department, located within each office location for which you are a patient. However, the revocation will not apply to uses or disclosures occurring prior to our receipt of your revocation request.

Rights of the Individual:

This form authorizes Seven Hills to use and / or disclose protected health information (PHI) in the manner described above and is voluntary. Seven Hills will not condition treatment, payment, enrollment or eligibility for benefits on the execution of this Authorization. The information used and/or disclosed as result of this authorization may be subject to redisclosure by the person or entity receiving such information and no longer may be protected by the federal privacy regulations.

Signature of the Patient or Legal Representative

_____/_____/_____
Date

If signed by Legal Representative, provide a description of the Legal Representative's Authority to sign on behalf of Patient

IMPORTANT NOTE: Authorization is not valid without a signature and date by the patient or authorized legal representative of the patient.

The request must be filled out completely. Scan this document into patient's GW/EHR Admin. Side