

**AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS  
TO SEVEN HILLS WOMEN'S HEALTH CENTERS**

Name of Facility/Provider to Release Medical Records: \_\_\_\_\_

Address of Facility/Provider to Release Medical Records: \_\_\_\_\_

Phone Number (\_\_\_\_\_) \_\_\_\_\_

Fax Number (\_\_\_\_\_) \_\_\_\_\_

I hereby authorize the above named Facility/Provider to release medical records in its possession, including information regarding my medical condition and treatments I have received to Seven Hills Women's Health Centers at the following location (please check appropriate location):

- |                                                                                                                                                           |                                                                                                                                                   |                                                                                                                                    |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> 4850 Red Bank Expressway, 3 <sup>rd</sup> Floor<br>Cincinnati, OH 45227<br><b>Fax # (513) 221-1320</b><br>Phone # (513) 221-2544 | <input type="checkbox"/> 20 Medical Village Dr., Suite 302<br>Edgewood, Kentucky 41017<br><b>Fax # (859) 578-2004</b><br>Phone # (859) 341-2510   | <input type="checkbox"/> 9312 Winton Rd<br>Cincinnati, OH 45231<br><b>Fax # (513) 922-2931</b><br>Phone # (513) 922-0009           |
| <input type="checkbox"/> 3301 Mercy Health Blvd. Suite 215<br>Cincinnati, OH 45211<br><b>Fax # (513) 481-3880</b><br>Phone # (513) 481-5100               | <input type="checkbox"/> 5680 Bridgetown Rd, Suite B<br>Cincinnati, OH 45248<br><b>Fax # (513) 389-7960</b><br>Phone # (513) 481-5300             | <input type="checkbox"/> 7495 State Rd, Suite 325<br>Cincinnati, OH 45255<br><b>Fax # (513) 624-2684</b><br>Phone # (513) 233-2000 |
| <input type="checkbox"/> 6903 Burlington Pike. Suite A<br>Florence, KY 41042<br><b>Fax # (859) 282-6760</b><br>Phone # (859) 282-6700                     | <input type="checkbox"/> 4843 Socialville Foster Rd., Suite 60<br>Cincinnati, Ohio 45040<br><b>Fax # (513) 229-8014</b><br>Phone # (513) 229-8010 | <input type="checkbox"/> 7495 State Rd, Suite 300<br>Cincinnati, OH 45255<br><b>Fax # (513) 231-3761</b><br>Phone # (513) 231-3447 |
| <input type="checkbox"/> 3747 West Fort Road<br>Cincinnati, Ohio 45247<br><b>Fax # (513) 389-0473</b><br>Phone # (513) 481-4777                           |                                                                                                                                                   |                                                                                                                                    |

I understand the information to be released may include information regarding the following conditions: sexually transmitted diseases, HIV/AIDS testing and status, drug or alcohol abuse and psychiatric conditions.

\_\_\_\_\_ Release medical records for date(s) of service \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ to \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

\_\_\_\_\_ Release these specific documents: **Other:** \_\_\_\_\_  
 Pap smear / HPV Typing                       Laboratory Results                       Prenatal Care  
 Surgical Op Note w/ Pathology                       Mammography Screening / Diag / Ultrasound

\_\_\_\_\_ Release entire medical record

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. However, the revocation will not apply to uses or disclosures occurring prior to our receipt of your revocation request.  
**Rights of the Individual:** You may inspect or copy information used or disclosed under this authorization. You may refuse to sign this authorization.  
**Effect of Refusing Authorization:** If you refuse to sign this authorization, Seven Hills will not deny you any treatment.

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 protected by the federal privacy regulations.

\_\_\_\_\_  
Print Patient Name

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date of Authorization

**IMPORTANT NOTE:** Authorization is not valid without a signature and date by the patient. The request must be filled out completely. Refusal to sign an authorization to have records transferred to Seven Hills will not result in an interruption of treatment.  
Form # 101-ALL Rev08/2015