Wellness for Women
GYNECOLOGY FOR WOMEN OF ALL AGES

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Authorization to Disclose Protected Health Information Date: _____

Patient: _____ DOB: _____
Address: _____ SS#: _____
_____ Chart #: _____

( ) I authorize Wellness For Women to **release information to:**

_____
Name of Provider of Facility
_____
Address
_____
City, State, Zip Code
_____ _____
Phone # Fax #

OR

( ) I authorize Wellness For Women to **obtain information from:**

_____
Name of Provider of Facility
_____
Address
_____
City, State, Zip Code
_____ _____
Phone # Fax #

I Hereby Request and Authorize Release of the Following Information:
(Please check appropriate areas)

( ) History and Physical
( ) Discharge Summary (Date: _____)
( ) Insurance Verification/Determination
( ) Significant Other Evaluation
( ) Psychiatric/Psychological
( ) Other (please specify): _____
( ) Progress Notes
( ) Telephone Calls/Nurses & MD Notes
( ) Laboratory Results
( ) Reports to Referral Source
( ) Operative Reports (Date: _____)
( ) Correspondence (specify):

I hereby authorize the release of the above information, including psychiatric, alcohol or other drug dependency history or treatment, and HIV/AIDS antibody testing results, to and/or from Wellness For Women. I hereby release the above from all legal liability that may arise from the release of the information requested. If in judgment of the medical staff the disclosure of certain information will be harmful if released to the patient, such information may be withheld in accordance with the specific state and federal regulations.

This consent will also serve as authorization to disclose information to any person, corporation or agency which is or may be liable for all or part of the physician charges or who may be responsible for determining the necessity, appropriateness, amount or other matter related to the treatment charges, including but not limited to, insurance companies and/or third party reviewers. I further authorize disclosure of the information to the program's insurance carrier when so requested by the carrier.

I understand that I may revoke this consent to release information in writing at any time, except to the extent that action has been taken in reliance thereon. In any event, upon fulfillment of the above stated purpose, this consent will automatically expire on the year from the date signed. I further understand that Wellness For Women reserves the right to notify the above named person, corporation or agency of the revocation in the event that I revoke this consent to release information.

Patient Signature: _____ Date: _____
Parent/Guardian: _____ Date: _____
Witness Signature: _____ Date: _____