HARBOUR WOMEN'S HEALTH

OBSTETRICS ● GYNECOLOGY ● UROGYNECOLOGY

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

PATIENT INFORMATION:

PATIENT NAME:_____

PATIENT DATE OF BIRTH:_____ **PATIENT PHONE NUMBER:**_____

PATIENT ADDRESS:_____

_____

AUTHORIZATION:

I give Harbour Women's health permission to release my protected health information to:

NAME: _____ PHONE NUMBER: _____

ADDRESS: _____

FAX NUMBER: _____ SEND BY: (PLEASE CIRCLE) MAIL FAX PATIENT PICK UP

_____

INFORMATION TO BE RELEASED:

Please note all requests will include the last three years unless specified under other.

- Office Notes
- Diagnostic Imaging
- Labs
- Most Recent Pap & Mammogram
- Last Operative & Pathology Report
- Entire Medical Record (Last 3 years)
- Other: _____

SENSITIVE INFORATION TO BE DISCLOSED:

Please initial:

_____ HIV Diagnosis / Treatment _____Mental Health _____ Genetic Testing

_____Sexually Transmitted Disease (STD) Diagnosis / Treatment_____ Alcohol & Substance Use / Treatment

PURPOSE:

☐ Continuation of Medical Care ☐ Transfer of Care ☐ Other:_____

SIGNATURE:

The information released pursuant to this authorization is confidential and must be used for the purpose that it was requested for; however, once this information is disclosed, the information may be subject to re-disclosure or release by the receiving party and may no longer be protected by federal and state confidentiality laws, unless protected by Federal Regulation 42 CFR Part 2 in which case it cannot be re-disclosed by the receiving party without my written authorization. I may revoke this authorization at any time in writing, provided the information has not already been disclosed in reliance on this authorization. This authorization is voluntary, and I may refuse to sign this form. I have the right to revoke this authorization at any time and that I must contact the medical records department to do so. This authorization is considered valid for a period of one year from the date of signature, or until _____.

Patient Signature:_____ **Date:**_____

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