Caring For Women

Authorization for Medical Records Release

This authorizes you to provide a copy, summary, or narrative of my medical records as indicated by the checkmark(s) below or otherwise release confidential information.

☐ Records concerning the following condition(s): _____

☐ Records of care for the following dates: _____

☐ Complete medical records: _____

☐ Other, please specify: _____

☐ Confer with person(s) listed below orally about my medical information: _____

Drug and/or Alcohol, and/or Psychiatric, and/or HIV/AIDS Records Release

I understand that the requested information may contain reference to or results of HIV/AIDS testing and/or treatment, drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information. I authorize the release of such confidential information to the indicated party, unless prohibited in my instructions above. **Initials_____ Date_____**

Re-disclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to Caring for Women. Unless revoked, this authorization will expire 1 year from date of signature. After this date, the entity named above can no longer use or disclose the patient's protected health information without first obtaining a new authorization.

Signature of Patient or Personal Representative Who May Request Disclosure

I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form unless specified below under *Purpose of Request*. I can view or receive a copy of the protected health information to be used or disclosed. I authorize Caring for Women to use and disclose the protected health information specified above.

Release From:

_____

_____

_____

Phone #: _____

Fax #: _____

Release To:

_____

_____

_____

Email : _____

Phone #: _____

Fax #: _____

The Purpose of Request for this release of information is as follows: _____

I understand that you will provide this information within **15 business days** from the date of receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners. I have been notified of this policy and agree to pay accordingly. **Patient Initials: _____**

Patient Name: _____ Maiden: _____ Date of Birth: _____

Patient /Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____