COMPLETE WOMEN CARE
BEST IN WOMEN'S HEALTH

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

I hereby request and authorize _____ Telephone _____
(Name of Physician)

Address _____ City _____ State ____ Zip _____

to release the healthcare information of the name stated at the bottom of this form.

This request and authorization applies to (Please be specific):

- ☐ Entire Medical Record:
- ☐ Other: _____

This information request is for the following purpose (mandatory in order to process request):

- ☐ Moved
- ☐ Change of Insurance
- ☐ Second Opinion
- ☐ Personal Reason
- ☐ Primary Care Physician Update
- ☐ Transfer of Care
- ☐ Other: _____

By signing below, you understand and agree to the following:

- I understand that I have the right to inspect or copy the protected health information that I have authorized to be disclosed.
- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by HIPPA.
- I understand that I may revoke this authorization at any time by giving written notice to the physician's office of my desire to do so. I also understand that I will not be able to revoke authorization in cases when the physician has already relied upon to use or disclose my personal health information.
- I understand that I may refuse to sign this authorization, and that you will not condition treatment on me with the exception of:
  1. When the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party OR
  2. For research related treatment in which case you may refuse to provide the research related treatment.

Signature: _____ Date: _____

Print Name: _____DOB: _____

Relationship to Patient (if signed by personal representative): _____