Southwest
WOMEN'S HEALTHCARE, INC.

Authorization for Release of Protected Health Information

I hereby authorize _____

To release information from the record of Patient Name: _____

Date of Birth: _____ SSN: _____

as described below to Facility/Person Name: _____

Phone: _____ Fax: _____

Records are requested for the purpose of (PROVIDE A DETAILED DESCRIPTION):

_____

The records to be released are: (identify all that apply) (please include approximate dates of service)

	All Records including but not limited to HIV, Psychiatric care and Drug and Alcohol		Inpatient Records; Dates:
	Progress Notes		Other (Specify)
	Mammography Report		Radiology
	Laboratory Test/Reports		Pathology
	Medical History and Physical Exam		Pap Smear
	Operative Report		

I understand the following:

- That my health record(s) will not be released or obtained by Southwest Women's Healthcare unless permission is provided for herein as evidenced by the signature on this Authorization for Release of Protected Health Information.
- That the release of my health record(s) will be for the purpose stated on this form, and only those items indicated will be released.
- That the health record(s) released by the facility/person authorized above may possibly be re-disclosed by the facility/person that receives the record(s) and therefore (1) its staff/employees have no responsibility or liability as a result of the re-disclosure and (2) such receives information would no longer be protected by the Privacy Rule.
- That this Authorization is in effect for a period of 90 days from the date of the signature, unless a specific time frame is documented; however no time frame specified shall go beyond one year from the date of signature.
- That I have the right to revoke this Authorization does not apply to any release of my health record(s) that may have taken place prior to the date of my request to revoke the Authorization.
- That my decision to revoke the Authorization may result in my insurance company not being able to pay for my medical care and I may be liable for payment of the claim.
- That I am entitled to a copy of this completed Authorization form.

*****SIGNATUER REQUIRED**

Patient Name: _____ Date: _____

The above named is unable to provide a signature due to: _____

Legal Representative Signature: _____ Date: _____

Relationship to Patient AND Description of authority to act on behalf of patient: _____