Patient Chart #_____

Contemporary Women's Health
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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Name:_____DOB:_____SSN:_____

PLEASE OBTAIN INFORMATION FROM:	**PLEASE SEND INFORMATION TO**
_____	_____
Doctor/Provider/Organization	**Doctor/Provider/Organization**
_____	_____
Address	**Address**
_____	_____
City, State and Zip	**City, State and Zip**
Ph:_____ Fax:_____	**Ph:_____Fax_____**

I AUTHORIZE THE FOLLOWING INFO TO BE RELEASED: (PLEASE INITIAL)

_____ALL Medical Records maintained at this facility

_____Other (please specify)_____

IF YOU DO NOT WANT CERTAIN PORTIONS OF YOUR MEDICAL RECORD RELEASED, PLEASE INITIAL BELOW THE RECORDS THAT ARE NOT TO BE RELEASED:

_____Substance Abuse, if any _____Psychological or psychiatric conditions, if any

_____AIDS/HIV, if any _____Other_____

PURPOSE OF RELEASE: (Please Initial)

_____At My Request _____Legal/Attorney _____Insurance

_____Continuing Care _____Social Security

_____Other (Please Specify)_____

~I understand that I may revoke this authorization, in writing, at any time and that unless an earlier date is specified it will automatically expire 12 months after the date affixed below. **To withdraw sign below*
~I understand that I do not have to sign this authorization to get treatment.
~I understand that once my health care information is disclosed as I have authorized it could be re disclosed by the recipients as I direct. Contemporary Women's Health, PLLC is not responsible for any subsequent release of this information that is not in compliance with federal confidentiality rules.
~I understand that signing this authorization does not cancel any rights I have under other state and federal laws.
~A copy of this authorization may be utilized with the same effectiveness as an original.

_____ _____
Patient Signature to RELEASE INFORMATION **Date**

FAX RECORDS MAIL RECORDS PICK-UP RECORDS

I wish to withdraw this authorization: _____ ***Date***_____