Women's Health Care
600 Primrose St Suite 202/ Medical Records
Haverhill, Ma 01830

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION PERMISSION TO SHARE INFORMATION

Patient's Name:	Date of Birth:
Address:	Telephone Number:

Permission to Share: I give my permission to share my individually identifiable health information, which may include protected or privileged information in written and/or verbal form.

From:	**To:**
Name: _____	Name: _____
Address: _____	Address: _____
_____	_____
FAX Number: _____	FAX Number: _____
Telephone Number: _____	Telephone Number: _____

Reason for the Information Transfer Request, (please check):

____ Transfer to New Primary Care Physician ____ Transfer to another OBGYN Office ____ 2nd Opinion
____ Moving ____Insurance ____Legal Matter ____ Personal

A copying service fee will be charged for records that are sent directly to a patient.

Information to be released for treatment dates: From _____ /_____ /_____ through _____ /_____ /_____

Documents to be released: Please check YES or NO for each of the following options:

YES	NO	
		Office Notes
		Laboratory Reports
		Pathology Reports
		Radiology Reports

YES	NO	
		Operative Report
		Medical Records Abstract (all records for last 3 yrs)
		Entire Medical Record

Release of Information Requiring Specific Consent: The following categories of information may be included in your medical record and *WILL NOT* be released unless you indicate your specific authorization by INITIALING each appropriate category.

____ Abortion ____ Behavioral/Mental Health ____ HIV/AIDS Results/Treatment
____ Alcohol/Drug Abuse ____ Domestic Violence ____ Rape/Sexual Assault
____ Genetic Testing ____ Sexually Transmitted Diseases

Please confirm that you have INITIALED all categories of information that you would like released.

I understand and agree that:

- The information which I authorize for release may be re-sent and is no longer protected by federal privacy regulations.
- I will be charged a fee for information that is sent directly to me.
- I decline the opportunity to inspect or copy the information released.
- I have received a copy of this authorization
- I may take back this authorization at any time by notifying the physician / hospital / clinic / organization from whom I am requesting this information in writing provided that the information has not already been released.
- This authorization is voluntary.
- My treatment will not be conditioned on the completion of this authorization.
- My questions about this authorization form have been answered.

This authorization expires 90 days from the date it was signed OR as specified: ____ /____ /____

X_____ or X_____ _____
Patient's Signature | Person authorized to sign for patient | Relationship to patient

Date: ____/____/____ Time: _____

Provider Initials: _____ Date: _____ OK to send: _____ Service Fee Charge: _____