The Woman's Clinic

Authorization for Use or Disclosure of Medical Record Information

Patient Information

Patient Full Name: ____ Date of Birth: ___________________

Patient Address: ____ Home Phone: ______________________

City: __________________________ State: ___________ Zip: _____________ Work Phone: ____________________

I hereby Authorize The Woman's Clinic (TWC) to:

[ ] RELEASE INFORMATION TO: ***OR*** [ ] TO OBTAIN INFORMATION FROM:

(Place an "X" in the box that indicates if the information is being released OR requested)

[ ] Mail Copies [ ] Hold for Patient Pickup [ ] Discuss Medical Information with

Name/Facility: ____ Attention: _______________________

Address: ____ Phone: _________________________

City: _________________________ State: ______________ Zip: ___________ Fax: ____________________________

Purpose of Request: [ ] Personal [ ] Continuing Care (second opinion or refer to specialist) [ ] Insurance [ ] Legal

[ ] Transfer Out (Reason? ___________________________) [ ] Other _______________________

Please send medical records to the following: [ ] 318-807-0809

Information to be Released:

[ ] Please provide all records

[ ] Other – Be specific, include dates and providers under comments.

Comments:____

____

Authorization to Release Protected Information

***Required** – Please complete the check boxes indicating how protected information should be handled Release Records?

Check One ***Initial*** **each line below to confirm your choices**

I [ ] **DO** [ ] **DO NOT** want my **Entire Record** released. ________

I [ ] **DO** [ ] **DO NOT** want information about **Mental Health Treatment** (other than Psychotherapy Notes) released. ________

I [ ] **DO** [ ] **DO NOT** want information about ***HIV Tests & Related Information** released. ________

I [ ] **DO** [ ] **DO NOT** want information about ***Genetic Testing Information** released. ________

I [ ] **DO** [ ] **DO NOT** want information about *** Hepatitis C Tests & Related Information** released. ________

I [ ] **DO** [ ] **DO NOT** want information about *** Alcohol and/or Substance Abuse** released. ________

I [ ] **DO** [ ] **DO NOT** want information about ____released. ________

Other sensitive information

I [ ] **DO** [ ] **DO NOT** want this information to be disclosed electronically. *TWC reserves the right to disclose Information electronically for treatment, payment, or healthcare operations, unless otherwise required by law.* _______

Please confirm that you have put a checkmark and initialed **ALL** the protected information categories above regardless of if they are applicable or not. If form is incomplete, or if protected information is not released, we may be unable to fulfill this request.

I specifically authorize TWC to disclose my Protected Health Information as described on this form to the recipients listed above. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by state or federal privacy regulations. I further understand that I retain the right to revoke this authorization, if done according to the steps set forth above.

I understand TWC is authorized by me to use or disclose my Protected Health Information for a purpose (described in this document) other than treatment, payment, or healthcare operations. I have read the authorization and understand what information will be used or disclosed, who may use and disclose this information, and the recipient(s) of that information. I understand that treatment, payment, enrollment, or eligibility for benefits may not be conditioned upon my signing this authorization.

____

Patient's Signature Date*

____

Parent/Legally Recognized Representative Signature** Date**

____

Witness Date

Know your Privacy Rights

Refer to HIPAA

"PRIVACY NOTICE"

If you wish to have another individual pick up your medical records from The Woman's Clinic, list his/her name below:
(ID MUST BE SHOWN AT THE TIME OF PICK UP)

____

Name of Individual Date

This Authorization is valid for 365 days (30 days for alcohol/drug abuse treatment) unless you specify otherwise: You may revoke this Authorization at any time by providing a written statement to the Health Information Management Department, except to the extent that ARC has already completed action on it.

By my signature, I attest that I am the legally recognized representative of the above-mentioned patient in accordance with the following: The information released pursuant to the Authorization may be disclosed by the receiving institution or individual to other individuals or organizations that are not subject to privacy protection laws.

CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS. This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 C.F.R. Part 2). The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general Authorization for release of medical or other information is NOT sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.