Health Care for Women

980 W. Ironwood Dr. Suite 101

Coeur d' Alene, ID 83814

Phone- (208) 765-1455 Fax-(208) 686-8312

AUTHORIZATION TO USE AND/OR DISCLOSE MEDICAL RECORDS

Patient Name _____ Date of Birth_____

Address_____

City_____ State_____ Zip_____Phone_____

I authorize Health Care for Women to **SEND/RECEIVE (circle one)** a copy of the specific health and medical information identified below:

TO/FROM (circle one) Name, Phone or Address -

_____

_____

For the following purpose/s: _____

By initialing the spaces below, I specifically authorize the use and/or disclosure of the following health information and/or medical records, if such information and/or records exist:

___Please send entire medical record

___Medical records needed for continuity of care

___Clinician office chart notes

___Laboratory reports

___Pathology reports

___GYN records

___OB records

___Other_____

The following items must be initialed as this may be included in the use and/or disclosure of your health care information:

___HIV/ AIDS related information

___Mental health information and/or records

___Genetic testing information and/or records

___Drug/alcohol diagnoses, treatment or referral info (federal regulations require a description of how much and what kind of info is to be disclosed. **Describe below:**

_____

I understand that, if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements. I also understand that the person I am authorizing to use and/or disclose the information may receive compensation for doing so. I further understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information to be used and/or disclosed under this authorization. Finally I understand that I may revoke this authorization in writing at any time, provided that I do so in writing, except to the extent that action has been taken in reliance upon this authorization. Unless revoked earlier, this authorization will expire in 180 days from the date of signing.

Signature of Patient or legal representative_____

Print Patient's Name_____ **Date**_____

Print Name of Legal Rep./relationship to patient (if applicable)_____