MEDICAL RECORDS RELEASE FORM

1) PATIENT INFORMATION:

Name ______ Address ______ City ______ State ______ Zip ______

Date of Birth ______ Daytime Phone (______) ______ Previous Name ______

2) AUTHORIZES:

Providence Women's Healthcare
Name of Medical Office

1300 Upper Hembree Road, Building 100, Suite D	Roswell	GA	30076	(770) 670-6170	(770) 670-6171
Address	City	State	Zip	Phone Number	Fax Number

3a) TO DISCLOSE TO:

☐ Self, Delivery Options: ☐Pick up ☐ Mail to address above

☐To be picked up: I hereby authorize ______ to pick up my records. (Photo ID required.)

Send to: ☐ ______
Name of Health Care Provider / Plan / Other

Address ______ Or Health Care Provider FAX # ______

3b) TO OBTAIN FROM: ______
Name of Health Care Provider / Plan / Other

Address ______ Phone Number (______) ______ Fax Number (______) ______

4) DATE(S) OF INFORMATION TO BE DISCLOSED/OBTAINED: From ______ (month/year) to ______ (month/year) **If left blank, only information from the past two (2) years will be disclosed/obtained.**

5) INFORMATION TO BE DISCLOSED/OBTAINED:

☐All medical records related to (specify condition, treatment, etc.): ______

☐Radiology films/images (specify test): ______

☐Specific records/information as follows: ______

I DO NOT WANT THE FOLLOWING INFORMATION DISCLOSED/OBTAINED (as defined by applicable state and federal laws):
☐Alcohol/Drug Abuse ☐HIV Test Results ☐ Mental Health / Developmental Disabilities

6) **EXPIRATION:** This Authorization is good until the following date / event: ______
Note: If this item is left blank, the authorization will expire in one (1) year from the date signed.

7) **PURPOSE** (Check all that apply - **copy fees apply**) ☐Transfer of Care ☐Insurance Eligibility/Benefits ☐Personal (at my request)

☐Other: ______

8) **YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:** I am aware that I have the right to inspect and receive a copy of the health information I have authorized to be used and/or disclosed by this Authorization. **I understand that I may be charged a fee for record copies.** In addition, I understand that I do not need to sign this Authorization in order to receive treatment. I also am aware that I may revoke this Authorization by notifying Providence Women's Healthcare in writing. However, I understand that my revocation will not be effective as to uses and/or disclosures: (1) already made in reliance upon this Authorization; or (2) needed for an insurer to contest a claim/policy as authorized by law if signing the Authorization was a condition to obtaining insurance coverage. I realize that the information used and/or disclosed pursuant to this Authorization may be subject to re-disclosure and no longer protected by federal privacy law.

9) **SIGNATURE OF PATIENT / LEGAL REP:** ______ **DATE:** ______

If signed by a person other than the patient, complete the following:
1. Individual is: ☐a minor ☐legally incompetent or incapacitated ☐deceased
2. Legal authority: ☐parent* ☐legal guardian ☐next of kin / executor of deceased ☐activated POA for Health Care

* By signing above, I hereby declare that I have not been denied physical placement of this child.

For Office Use Only:

Signature/ID verified ☐Yes ☐No Completed by: ______ *Date* released ______ # of pages______