Associates In Women's Care, P.C.

Authorization to Release Healthcare Information

Phone: (719)591-6666 Fax: (719)573-0731

This release expires 90 days from the date of signature or upon written notification

Patient's Name: _____

Date of Birth: _____ *Social Security Number:* _____

Previous name under which records may be filed: _____

Patient's Address: _____

_____*Phone:* _____

Doctor's Name: _____ *Approximate last visit date:* _____

I authorize the health care provider to release copies of my health record to the following:
Name: _____
Address: _____
City: _____ *State:* _____ *Zip:* _____
I understand that when the information is released, it may be subject to re-disclosure by the recipient and may no longer be protected Personal Health Information (PHI).
I specifically authorize the release of information regarding the following condition(s): If these are not marked we CAN NOT release.

☐ *Drug Abuse if Any*

☐ *Substance Abuse if Any*

☐ *Psychological or Psychiatric Conditions if Any*

☐ *AIDS/HIV if Any*

_____ *All records generated in this office.*
_____ *Other:* _____
(specific dates of treatment or specific parts of the record)

We can only copy your records. We CAN NOT forward copies of your records that we have received from any other physician. You will need to obtain these records directly from the physician providing your care.
Are you leaving the practice? Yes _____ No _____
If yes, please explain: _____

Request for medical records may require up to 10 days to process. Our charge for copying medical records is $5.00 for 1-5 pages and $14.00 for 6-10 pages. Over 11 pages there will be a charge of $.50 per page, and over 40 pages there will be a charge of $.33 per page. There is no charge for records sent to another physician.

Patient Signature : _____ *Date:* _____
(or legally authorized representative)
Relationship to Patient if legal representative : _____