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: _____

_____

Patient's Phone Number: _____

PLEASE FORWARD COPIES OF MY MEDICAL RECORDS

FROM: _____ *TO: Associates In Women's Care, P.C.*
_____ *6011 E. Woodmen Rd, Suite 320*
_____ *Colorado Springs, CO 80923*

I authorize the health care provider to release the information specified below to the organization, agency or individual named on this request for the following reason:

_____

_____

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*

We can only copy our 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.

_____ *All records generated in this office.*

_____ *Other:* _____

(specific dates of treatment or specific parts of the record)

Are you leaving the practice? Yes _____ No _____

If yes, please explain: _____

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).

Patient Signature : _____ *Date:* _____

(or legally authorized representative)

Relationship to Patient if legal representative : _____