COVINGTON WOMEN'S HEALTH SPECIALISTS

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name_____ Date of Birth_____

Phone _____ Email_____

Address _____ City/State/Zip_____

Maiden Name_____

Above listed patient authorizes **Covington Women's Health Specialists** to make record disclosure by

_____Mail_____ Email_____ USB Flash drive (fees apply)

Release To_____

Address_____ City/ST/Zip: _____

Phone_____ Fax_____

Dates and type of information to disclose:

- o Entire Medical Record (includes genetic testing)
- o Abstract of record
- o Specific information_____

The purpose of this disclosure is:

- o Change of insurance
- o Referral
- o Other_____
- o Transfer

Only medical records originated through this healthcare facility will be copied unless otherwise requested.
This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.
I understand the information in my health record may include information related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug use.
I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the medical records department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked this authorization will expire 90 days from the date signed.
I understand that the authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of information to be used or disclosed, as provided in CFR 164.524
I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have a question about the disclosure of my health information, I can contact the authorized individual organization making disclosure.
Records for treatment purposes may be faxed to the patient's healthcare provider when requested at no additional cost.

I have read the above foregoing authorization for release of information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

_____ _____

Patient of Legal Representative Signature Date

_____ _____

Printed Name or Authorized Representative Relationship/Capacity of patient