



WOMEN'S HEALTH
SPECIALISTS
OF ADVANTIA

Authorization For Release of Medical Information

Patient's Full Name

Patients Social Security Number

Address

Patient's Date of Birth

City, State, Zip Code

Patient's Telephone Number

At the request of the individual, I _____, do hereby authorize _____ to release:

Information Release To:

Name of Company/Agency/Facility/Person

Address

Phone Number

Fax Number

City, State, Zip Code

The specific information that should be disclosed is (include dates of service):

UNLESS YOU SIGN HERE, NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED.

YES, DISCLOSE THIS INFORMATION * _____

NO, DO NOT DISCLOSE THIS INFORMATION * _____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of person or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING – Note that Signature is required in two places.*

Signature of Individual

Date of Individual's Signature

Date of Birth or Social Security Number

Signature of Guardian or Personal Representative of Patient's Estate

Date of Guardian's/Representative's Signature

Description of Authority to Act for the Individual

A copy of this completed, signed, and dated form must be given to the Individual or other signator.

FEES FOR COPIES: Federal and state law permits a fee to be charged for the copying of patient records. This facility may contract with a business associate to provide this service and they will invoice you directly. You may be required to pre-pay for the copies; if not, then your copies will be mailed along with an invoice.

Official Use Only

Received

Processed By

Log #

Electronic Record Delivery Request

Complete this form, along with a HIPAA Authorization, to receive your medical records as electronic PDF files rather than as printed copies.

Requester Name	First	Last	
Street Address	Street	Suite / Apt #	
	City	State	Zip
Email Address for record delivery:			
Medical Records Requested			
Patient Name	First	MI	Last
Date of Birth			
Date of Service	From	To	

Please provide me with the medical records described above. I understand and agree that:

- I must provide a valid email address, either my own or that of my designated recipient.
- My records will be provided as PDF files.
- I will receive an email containing instructions for accessing my records.
- If I do not retrieve my records within 30 days, they will be deleted.
- There may be a fee for collecting my records. If so, an invoice will be included with the records.

Signature _____ Date: _____