

ALEXANDRIA WOMEN'S CENTER

Authorization for Release of Protected Health Information

1. Patient Information

Patient Name _____ Date of Birth ____ / ____ / ____

Patient Address _____
Street City State Zip

Patient Home Phone _____ Patient Email _____

2. Recipient Authorization

I _____ hereby authorize Alexandria Women's Center to release a copy of my medical record to _____
(name) (address) (phone #)

3. Information to be Released. Check all that apply and specify dates of service.

- Entire Medical Record _____ Lab Reports _____
- Visit Notes _____ X-Ray Reports _____
- Pathology Reports _____ Other (specify) _____
- Psychotherapy Notes _____ (If so, this is the only item you may request on this authorization)

4. Purpose of Information Release

- Further medical care Disability Determination
- Payment of Insurance Claim Vocational rehab, evaluation
- Legal Investigation At the request of the individual
- Applying for Insurance Other (specify): _____

5. Inclusion of Privileged Information

I understand that if my record contains information concerning alcohol or drug abuse/treatment, information concerning abortion, HIV testing and related information, AIDS-related conditions, genetic testing, STDs, domestic/sexual abuse, or developmental disabilities, such information is included in this disclosure.

6. Patient Rights and Privacy

- I understand that I do not have to sign the authorization in order to receive treatment or payment, or to enroll or be eligible for benefits. I understand that I may revoke this authorization at any time, except to the extent that the individual or entity that is to make the disclosure has already completed action on it.
- I understand that protected health information disclose pursuant to this authorization may be re-disclosed by the recipient to other individuals or organizations that are not subject to privacy protection laws.
- I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I request it.
- I understand that Alexandria Women's Center will not condition treatment on whether I sign the authorization. **This authorization will automatically expire one year from the date signed.**

Signature of Patient: _____ Date: _____

Signature of Legal Representative: _____ Date: _____