Affinity
WOMEN'S HEALTH CARE

Dr. Susan Catt, OB/GYN Heather Porto, CNM Amy Pheiffer, APN Shannon Graves, APN

## **AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION**

Patient Name:		Phone No.:		
Patient Address:				
Date of Birth:	Medical Chart No.:			
<u>Purpose of copying records</u> :	□ Transfer	of care		
	□ Referral t	o specialist		
	□ Other:			
Reason for Transfer:				
Practice Name:				
Practice Address:Street			State	
Practice Phone No.:		-		
<u>Information to be disclosed</u> :				
☐ History & Physical ☐ Pro	•		□ X-Rays,	/Imaging
□ Operative Reports □ Oth	er:			
HIGHLY CONFIDENTIAL informat	ion to be discl	osed:		
☐ HIV/AIDS related health inform	ation	□ Behavioral or m	ental health	information
□ Drug/Alcohol diagnosis, treatm	ent, referral in	formation 🗆 G	enetic testing	g information

## Lunderstand:

- ❖ That I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. In the event I refuse to authorize the release of the above-described information, I understand that it will not be disclosed, except as provided by law.
- ❖ That the practice may not condition treatment on whether I sign this authorization, except when the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.
- ❖ That information used or disclosed pursuant to this authorization may subject to redisclosure by the recipient and may no longer be protected by law.
- That this authorization is valid until it expires, unless revoked before the date provided.
- ❖ That I may revoke this authorization at any time by giving a dated written notice of my desire to do so to the physician. I also understand that I will not be able to revoke this authorization in cases where the physician has already relied on it to use or disclose my health information. A dated written revocation must be sent to the physician's office.
- ❖ That I have read and understand the terms of the authorization and I have had the opportunity to ask questions about the use and disclosure(s) of my health information.
- **❖** There is a copy fee of \$25.

Witness Signature

information as described above.	
X Printed Name of Patient, Legal Guardian, or Authorized Agent	// Date
X Signature of Patient, Legal Guardian, or Authorized Agent	
Relationship to Patient	

By signing below, I knowingly and voluntarily authorize the disclosure of my protected health