AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION
FROM WOMEN'S CARE CENTER OF COLUMBUS, INC.

I, _____, authorize Women's Care Center of Columbus,
PATIENT'S NAME
Inc. to release the following protected health information as described below:

Release Information To:_____
FULL NAME OF PHYSICIAN OR PERSON TO RECEIVE RECORDS

_____
COMPLETE ADDRESS OF PERSON TO RECEIVE RECORDS

_____
FAX NUMBER

Information to be released (required)

☐ Records from (date) _____ to (date)_____

☐ Entire medical record (including patient history, office notes, test results, radiology, referrals, consults, records sent by other healthcare providers). I understand my my medical record may include one or more of the following: treatment of communicable diseases (including sexually transmitted diseases, sensitive medical information, HIV, drug and alcohol use mental health unless checked to omit below)

☐ Other:_____

Purpose of Release:_____

Expiration: This authorization will expire on _____(date)

Revocation: The patient may revoke this authorization in writing at any time, except to the point that the medical practice has acted in reliance on this authorization.

Re-disclosure: Information used or disclosed under this authorization will be given to recipients who may re-disclose the information and those later disclosures may not be protected by law.

Patient's Rights: The patient may inspect or copy the protected information used or disclosed pursuant to authorization and may refuse to sign this authorization. Except where allowed by law, the Medical Practice will no condition treatment, payment or other health care benefits on the giving of this information.

HIV, Mental Health and Drug and Alcohol information contained in the parts of the records indicated above will be released through this authorization unless otherwise indicated.
DO NOT RELEASE ___ HIV, ___Drug & Alcohol, ___ Mental Health (psychiatric)

_____ _____ _____
SIGNATURE OF PATIENT (OR GUARDIAN IF MINOR) PATIENT'S BIRTHDATE TODAY'S DATE