Warsaw Women's Center
Records Request

Authorization for Use and Disclosure of Protected Health Information (PHI)

_____
Doctor/Facility

_____
Address

_____
City State Zip Code

Information To Be Released – Covering Periods of Health Care:

From (date) _____ To (date) _____

Check type of information to be released:

[ ] Entire medical record [ ] Laboratory Results from date _____ to _____

[ ] Most recent 3 years of records [ ] X-ray reports from date _____ to _____

[ ] X-ray films (type) _____ date _____

[ ] Other: _____

Purpose of Request

[ ] Treatment or consultation [ ] At the request of the patient [ ] Billing or claims payment

[ ] Other (specify) _____

I understand that the medical information released by this authorization may include information concerning treatment of physical and mental illness, alcohol/drug abuse and past medical history.

Time Limit and Right to Revoke Authorization

I understand this authorization will expire, without my express revocation, one year from the date of signing, or if I am a minor, on the date I become an adult according to the law. Unless revoked, this authorization will expire on the following date _____. If no date is completed in space above, authorization will expire one year from date of signature.

Re-disclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Personal Representative Who May Request Disclosure

I understand that Warsaw Women's Center, P.C. may not condition my treatment on whether I sign this authorization form unless specified above under Purpose of Request. I can inspect or copy the protected health information to be used or disclosed. I authorized Warsaw Women's Center, P.C. to use and disclose the protected health information specified above.

Printed Name: _____ SS#: _____

Signature: _____ DOB: _____

Date: _____

Authority to sign if not patient: _____

PLEASE RELEASE REQUESTED RECORDS TO:

WARSAW WOMEN'S CENTER
1275 PROVIDENT DRIVE
WARSAW, IN 46580
FAX: 574-269-7444