



CAPITAL
WOMEN'S
CARE

**AUTHORIZATION TO RELEASE PATIENT MEDICAL INFORMATION
PATIENT INFORMATION TO CAPITAL WOMEN'S CARE**

Patient Name: _____ Acct.# _____

Former Name (if any) _____ SS. # _____

Daytime Telephone _____ Birth date ____/____/____

INFORMATION TO BE RELEASED FROM:

I hereby authorize _____ (NAME OF OTHER PROVIDER
RELEASING INFORMATION) to use and disclose my individually identifiable Protected Health
Information (PHI) in the manner described below. I understand that my PHI may be redisclosed by the
person or entity receiving my PHI from the above named provider, and that it then may no longer be
protected by federal privacy regulations. State law may or may not prohibit such redisclosure by the person
or entity receiving my PHI from the above named provider. I voluntarily sign this authorization, and I
understand that my health care will not be affected if I do not sign this form.

PROTECTED HEALTH INFORMATION TO BE RELEASED TO:

Name of Organization	Site Location:	Street Address	City/State/Zip
<u>Capital Women's Care</u>	_____	_____	_____

Purpose or need for this information is: _____

TYPE OF INFORMATION TO BE RELEASED:

1. GENERAL RELEASE:

Type of Record

- Medical Records/Excluding Protected Records
(This will be limited to 2 years of information including x-ray, Lab reports unless otherwise stated).
- Lab Results (specify) _____
- X-ray Reports (specify) _____
- Surgical records (specify) _____
- Other Records (specify) _____

2. INFORMATION PROTECTED BY STATE/FEDERAL LAW:

- Drug Abuse Diagnosis/Treatment (specify) _____
- Alcoholism Diagnosis/Treatment (specify) _____
- Mental Health Diagnosis/Treatment (specify) _____
- Sexually Transmitted Disease (specify) _____
- Diagnosis/Treatment or Counseling (includes Aids/HIV) (specify) _____

I understand that I have the right to receive a copy of this authorization. I also understand this
authorization is valid for 90 days only and may be revoked in writing at any time prior by
notifying _____ (Name of Entity Releasing Information) in writing.
I understand I have the right to revoke the authorization at any time except to the extent that
action has been taken in reliance thereon.

PATIENT AUTHORIZATION TO RELEASE MEDICAL INFORMATION

_____ X _____
Date Signature of Patient/
Legally Responsible Party Relationship to
Patient if not Patient