SEVEN HILLS
Women's Health Centers
Special Care for Every Stage of Your Life

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

(Please print)

Patient Name: ______________________________ Last Four Digits of Social Security _______________

Address: ______________________________ Patient Date of Birth: _______/_______/_______

______________________________ Patient Phone No.: _______-_______-_______

Release Authorization: (Please print) Patient GW ID ___________________

I ______________________________hereby authorize Seven Hills Women's Health Centers to release medical records in its possession, including information regarding my medical condition and treatments I have received. I understand the records to be released may include information regarding sexually transmitted diseases, drug or alcohol abuse, HIV/AIDS testing and status, and psychiatric condition.

______ Release medical records for date(s) of service ____/____/____ to ____/____/____.

______ Release copy of complete medical record

______ Release only those records for items checked below:

history and physical for date(s) of service ____/____/____ to ____/____/____.

cytology reports for date(s) of service ____/____/______ to ____/____/______.

operative notes for date(s) of service ____/____/______ to ____/____/______.

pathology reports for date(s) of service ____/____/______ to ____/____/_____.

discharge summary regarding _________________________on ___/___/_____.

______ Release other specific medical record information.
Specify: ____

To Whom the Records are to be Released:

Seven Hills Women's Health Centers is authorized to disclose the above designated protected health information to the following person or entity:

______ Records are to be mailed to: Name of Recipient: ___________________________

Recipient Address: ___________________________

____

______ Records are to be picked up by me, the patient, or legal patient representative. (Photo ID must be presented at this time)

Purpose of Use or Disclosure:

Purpose or reason for the use and/or disclosure of the information requested: __________________________

____

Expiration Date of Authorization: The authorization will automatically expire one (1) year from the date of signature. We will not honor requests for disclosure after expiration without an updated authorization form. You may renew or alter this authorization form at any time.

Right to Terminate or Revoke Authorization: You may revoke or terminate this authorization by submitting a written revocation to Seven Hills Women's Health Centers Medical Records Department, located within each office location for which you are a patient. However, the revocation will not apply to uses or disclosures occurring prior to our receipt of your revocation request.

Rights of the Individual:

This form authorizes Seven Hills to use and / or disclose protected health information (PHI) in the manner described above and is voluntary. Seven Hills will not condition treatment, payment, enrollment or eligibility for benefits on the execution of this Authorization. The information used and/or disclosed as result of this authorization may be subject to redisclosure by the person or entity receiving such information and no longer may be protected by the federal privacy regulations.

____ ______/_______/_______

Signature of the Patient or Legal Representative Date

____

If signed by Legal Representative, provide a description of the Legal Representative's Authority to sign on behalf of Patient

IMPORTANT NOTE: Authorization is not valid without a signature and date by the patient or authorized legal representative of the patient. The request must be filled out completely.

Form 102-ALL Rev 11-2014