GENERAL MEDICAL RECORDS RELEASE AND AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize: To release to:

_____ _____
(Organization/Physician Name) (Organization/Physician Name)

_____ _____
(Phone/Fax Number) (Phone/Fax Number)

This authorization permits **Women's Health Specialists** to use and/or disclose the following individually identifiable health information about me:

___Complete Health Record ___Laboratory Tests
___Mammogram Reports/Films ___Progress Notes
___Other (Please Specify) _____During Month/Year: _____

This information will be used or disclosed for the following purpose:

___Continuing Care ___For Insurance purposes ___Legal Action
___At the request of the individual (This may be checked only if records are requested by the patient)
___Other (Must Describe) _____

I specifically authorize release of information relating to:

___HIV Test results for non-treatment purposes ___Substance Abuse Service Provider Client Records
___Psychiatric, Psychological or Psychotherapeutic notes

I understand there may be a charge for copying my records as provided under federal and state law.

The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosers of the above information to the extent indicated and authorized herein:

Patient Name: _____ D.O.B: _____

Signature of Patient or Legal Representative: _____ Date: _____

Witness: _____ Date: _____

The patient information requested above may not be further disclosed to any party under any circumstances except with the patient's express written consent or as otherwise permitted by law.
The information may not be used except for the need specified above.

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked in writing, this authorization will expire in 60 days from the date of execution or

_____.
(Expiration Date or Defined Event)

My written revocation must be submitted to the WHS Privacy Officer, 3498 NW Federal Highway, Jensen Beach, FL 34957.
A Photocopy of FAX is valid as the original.

Mail Form to: Medical Records Department, Women's Health Specialists, 3498 NW Federal Highway, Jensen Beach, FL 34957, or FAX to (772) 771-0258