WOMEN'S HEALTH SPECIALISTS OF NORTH TEXAS

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize the use or disclosure of information from the medical record of:

Patient Name: _____ **Medical Record#:** _____ **DOB:** _____

I authorize the following individual or organization to disclose the above named individual's health information:

To: _____Address: _____
-OR-
From: _____ Address: _____

For the purpose of: _____

Entire Record **(PLEASE CHECK ALL THAT APPLY)**
-OR-

☐ Problem list
☐ Progress notes
☐ History/Physical exam
☐ Medication list
☐ Immunization record
☐ List of Allergies
☐ X-Ray Imaging report from (date ____ (date) ____
☐ Laboratory results from (date ____ to (date) ____
☐ EKG films
☐ Genetic testing information
☐ Other Diagnostic Reports (specify) _____
☐ Other (specify) _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired Immunodeficiency syndrome (AIDS), or human Immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol the drug abuse.

☐ **Yes, I consent to the release of this information.** ☐ **No, I do not consent to the release of the information.**

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.
I understand that I have a right to revoke this authorization at any time. **I understand** that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing the information. **I understand** that revocation will not apply to information already released in response to this authorization. **I understand** that the revocation will not apply to my insurance company when the law provides my Insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire when the patient has done so in writing.
I understand that authorizing the disclosure to this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. **I understand** that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. **I understand** that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentially rules. If I have questions about disclosure of my health information I may contact the Office Manager.

_____ _____ _____ _____
Patient Signature-or-Legal Guardian Date Signed Witness Date Witnessed

COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT: I understand that my medical record may contain reports, lab results and notes that only a physician can interpret. **I understand** and have been advised that I should contact my physician regarding the entries made in my medical record, to prevent my misunderstanding of the information contained in these entries. I will not hold **WOMEN'S HEALTH SPECIALISTS OF NORTH TEXAS OR ANY PHYSICIAN** liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

_____ _____ _____ _____
Patient Signature-or-Legal Guardian Date Signed Witness Date Witnessed