MIDWEST CENTER
FOR
WOMEN'S HEALTHCARE

Exceptional care one patient at a time.

Authorization Form for Release of Confidential Health Information

By my signature below, I hereby authorize Midwest Center for Women's HealthCare (and/or ***[State name of other health care facility, if applicable]***) ____to release to:

(*State name of physician/facility to receive information*):

____

The following information contained in the patient record of ***(state name of patient)***:

____

Born on **(state birth date of patient)**: ____

Residing at **(state address of patient)**:

____

(Street Address, City, State and Zip Code)

☐ The entire medical record, ***excluding*** mental health treatment, alcoholism treatment, drug abuse treatment, and HIV/acquired immune deficiency syndrome (AIDS) records

To be disclosed, the following items must specifically be checked*:*

- ☐ Mental Health Treatment Records
- ☐ Alcoholism Treatment Records
- ☐ Drug Abuse Treatment Records
- ☐ HIV/Acquired Immune Deficiency Syndrome (AIDS) Records
- ☐ Laboratory Reports
- ☐ X-ray Reports
- ☐ Operative Notes
- ☐ Other *(please specify)*: ____

I understand that I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. In the event I refuse to authorize the release of the above-described information, I understand that it will not be disclosed, except as provided by law.

I understand that Midwest Center for Women's HealthCare may not condition treatment on whether I sign this authorization, except when the provision of healthcare is solely for the purpose of creating protected health information for disclosure to a third party.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by law.

I understand that this authorization is valid until it expires, unless revoked before that.

I understand that I may revoke this authorization at any time by giving written notice to Midwest Center for Women's HealthCare of my desire to do so. I also understand that I will not be able to revoke this authorization in cases where the physician has already relied on it to use or disclose my health information. Written revocation must be sent to the physician's office.

____

Signature

____

Date

____

Date of Expiration of this Authorization

(if no date is specified, this Authorization will automatically expire in sixty (60) days)

____

Relationship to Patient (if not patient)