healthcare designed for women

Authorization for the Release of Medical Information

Patient Information

Last Name:		First Name:		Middle:		Maiden:	
Date of Birth:		Social Security #:					

Choose one option:

☐ I hereby authorize A Woman's View to release the medical records described below to:

Name of Organization:					
Street Address:					
City:		State:		Zip Code:	
Telephone:		Fax:			

☐ I hereby authorize _____ to release the medical records described below to:

A Woman's View
915 Tate Blvd. SE, Suite 170
Hickory, NC 28602
Phone: (828) 345-0800 Fax: (828) 345-0350

The purpose of the use or disclosure is:		
Time period for medical records that are being released:	From:	To:

The patient or the patient's representative must read and initial the following statements:

I understand that this authorization will expire on: _____

_____
Initials

I understand that I may revoke this authorization at any time by notifying A Woman's View, P.A. in writing, but if I do it will not have an effect on any actions taken in reliance on my authorization before the practice received the revocation.

_____
Initials

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NOTICE TO PATIENTS:

The patient or the patient's representative may inspect and/or copy the health information to be used or disclosed in accordance with A Woman's View policies. You may refuse to sign this authorization. A Woman's View, P.A. will not condition treatment or payment on your providing this authorization except in the specific circumstances allowed by the Privacy Rule.

I hereby authorize the use or disclosure of my individually identifiable health information as described above. I understand that this authorization is voluntary. I understand that when the information is used or disclosed, it may be subject to being redisclosed and may no longer be protected by federal privacy regulations.

Patient Name:		Birth Date:	
Signature:		Today's Date:	
Printed name of patient's representative, if applicable			
Representative's Authority:			

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