WOMEN PHYSICIANS IN OB-GYN, INC.
AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I hereby authorize the use and disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the person or organization authorized to receive the information is not a health plan or health provider; the released information may no longer be protected by federal regulations.

Patient name: _____ ID/Acct Number: _____
DOB/MRN# _____ **(for office use only)**

Persons/organizations **providing the information**:
(Name/address/phone/fax)

Person/organizations **receiving the information**:
(Name/address/phone/fax)

Specific description of information (including date(s) of service):

Please check all that apply:
___ All Medical Records
___ Visit dates _____ to _____
___ Diagnostic Tests (Lab, Xray,Other)
___ Most recent office visit
___ Prenatal records for current pregnancy
___ Other: _____

Purpose of the disclosure:_____
_____
_____

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

1. I understand that this authorization will expire on __/__/____ (MM/DD/YYYY)
   INITIALS _____

2. I understand that I may revoke this authorization at any time by notifying the practice in writing, but if I do, it won't have any effect on any actions they took before they received the revocation.
   INITIALS _____

3. I understand that my health care and the payment for my health care will not be affected if I do not sign this form.
   INITIALS: _____

Signature of patient or patient's guardian_____ Date:_____
(*Form MUST be completed before signing*)

Printed name of patient or patient's personal representative_____
Relationship to patient _____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION