WOMENS HEALTH GROUP

121 Northwest Avenue, Tallmadge, Ohio 44278 – PH: 330-633-1350/FAX: 330-633-6068
919 E. Turkeyfoot Lake Road, Akron, Ohio 44312 – PH: 330-899-9626/FAX: 330-633-6068

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL RECORDS

PATIENT IDENTIFICATION:

Patient Name: ______________________________ Date of Birth: ________________

Address: ______________________________ SS#: ______________________

______________________________ Phone: ____________________

INFORMATION TO BE RELEASED FROM:

Facility/Physician Name: ____

Address: ____

Phone: ________________________ Fax: ______________________________

Please check type of information to be released:

☐ Entire Record ☐ Lab Report ☐ Emergency Dept. Record
☐ History and Physical ☐ Pap Smear ☐ Operative Report
☐ CT/MRI ☐ Mammogram ☐ Pathology Report
☐ Ultrasound Report ☐ Bone Density Report ☐ Discharge Summary
☐ Other: ____

Dates of Service: ____

PURPOSE OF DISCLOSURE

☐ Health Care ☐ Billing ☐ Personal ☐ Legal ☐ Other: ____________________

INFORMATION TO BE RELEASED TO: (Facility/Physician Authorized to Receive Records):

Facility/Physician Name: Womens Health Group Incorporated

Address: 121 Northwest Avenue, Tallmadge, Ohio 44278

Phone: 330-633-1350 Fax: 330-633-6068

The patient acknowledges and understands the medical record may contain information regarding psychiatric disorders, drug and alcohol abuse, HIV results, a diagnosis of AIDS or an AIDS related condition and expressly consent to the release of any such information contained in the records designated above.

I acknowledge that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by the HIPAA Privacy Rule, 45 C.F.R. 164.508 (c)(2).

This authorization may be revoked if written request is received prior to information release. This authorization will expire in 90 days from date of signing.

SIGNATURE OF PATIENT/RESPONSIBLE PARTY:

Patient/Responsible Party Signature: ____

Date Signed: ____