SOUND
WOMEN'S
CARE

Authorization to Release Patient Health Care Information

Patient's Name _____ Date of Birth _____

SSN _____ Previous Name _____

I request and authorize:

Name _____

Address _____

City, State _____ Zip Code _____

to use or release the following health care information contained in my medical record:

Type of Record

☐ Last two years of medical records, including any earlier surgeries and abnormal lab reports.

☐ Health care information relating to the following treatment or condition: Dates of treatment:
(MO/DAY/YR) (MO/DAY/YR)
_____ From ___/___/___ To ___/___/___

☐ Other (e.g., X rays, lab reports) _____From ___/___/___ To ___/___/___

I understand that my express consent is required to release any health care information relating to testing diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed, or treated for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing, or treatment.

You may release this health information of the patient named above to:

Name _____ _____
Institutional Affiliation

Address _____

City, State _____ Zip Code _____

_____
Signature of patient or legally authorized individual Date Signed

_____
Printed name if signed on behalf of the patient Relationship
(Parent, legal guardian, personal representative)

This authorization expires within 90 days after it is signed, and I understand that I have the right to revoke this authorization in writing at any time, providing the information has not already been disclosed. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

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