Pacific Women's Center
Physicians and Surgeons

Authorization to Release & Discuss Protected Health Information Between PWC & Person(s) Designated by the Patient.

Patient Name: _____

Date of Birth: _____ _____Phone: _____

I authorize Pacific Women's Center, LLC to contact me by the following designated options: (Please initial all that apply)

_____ Leave medical information on my home/cell answering machine.

_____ Contact me at work.

_____ Leave medical information on my work voice mail.

_____ I understand the answering lines and voice mail must reference my name and/or phone number as listed on my account.

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I authorize Pacific Women's Center, LLC to discuss the following medical information with the persons listed below for a period of three years or upon my written cancellation of this document. (Please initial all that apply)

The type and amount of information to be used or disclosed is as follows: (include dates where appropriate).

_____Complete Health Records (limited to 3 years) _____ Lab results/Ultrasound reports

_____Office chart notes _____Consultation reports

_____Hospital records _____Entire medical records

_____ Authorization to disclose **ALL** my medical care with:

RELEASE OF INFORMATION TO: (Print) _____

(Relationship) (Phone)

RELEASE OF INFORMATION TO: (Print) _____

(Relationship) (Phone)

1. *I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.*
2. *This information may be disclosed to and used by the following individual, medical group, or organization:*
   For the purpose of: ***Discussing my health care***
3. *I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date: _____.*
4. *I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not to sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information I can contact: Dawn Crump- Privacy Officer for: Pacific Women's Center, LLC.*

_____ _____

Signature of patient or legal representative Signature of witness

Date: _____ Date: _____

REVOCATION OF THIRD PARTY RELEASE OF INFORMATION: I hereby cancel this authorization effective the date of my signature below.

_____ _____

Signature of patient or legal representative Signature of witness

Date: _____ Date: _____