HENDERSON & WALTON
WOMEN'S CENTER, P.C.

Authorization to Disclose Health Information

Patient Name: _____ Date: _____

Social Security #: _____ Date of Birth: _____

Patient phone #: _____

1. I authorize the use or disclosure of the above named individual's health information as described below.

2. The following organization is authorized to make the disclosure:

   _____

   _____

   _____

3. Description of the information to be used or disclosed (check all that apply):

   ( ) The patient's entire medical record
   (NOTE: This requires an explanation why the entire record may be disclosed).

   ( ) The patient's demographic information (check all that apply):
   ( ) Name ( ) Address ( ) State/Zip Code only ( ) Telephone
   ( ) Age ( ) Gender ( ) Race ( ) Other: _____

   ( ) Medical Data/Information as related to:
   ( ) Specific condition (s): _____
   ( ) Specific professional service (s): _____
   ( ) Specific medication (s): _____
   ( ) Other: _____

( ) Other: _____

4. Please release the above information to the following physician or individual (s):

   Physician or Individual name _____
   Address: _____
   Phone#: _____

5. 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 behavior or mental health services, and treatment for alcohol and drug abuse.
6. 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 and present my written revocation to the Health Information Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. 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, event, or condition: _____, If I fail to specify an expiration date, event or condition, this authorization will expire 1 year from today's date.
7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of 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 the disclosure of my health information, I can contact the Health Information Department.

_____ _____
Signature of Patient of Legal Representative Date

_____ _____
If signed by Legal Representative, Relationship to Patient Signature of Witness