

Center for Women's Health
4840 College Blvd
Overland Park, KS 66211
Phone: (913) 491.6878
Fax: (913) 491.6808

**AUTHORIZATION TO DISCLOSE/RELEASE OR
OBTAIN MEDICAL RECORDS**

All disclosures are following Federal and State laws, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), governing the use and disclosure of Protected Health Information (PHI).

I hereby authorize **Center for Women's Health** to: **disclose/release to** **obtain from**

(Name of person or Organization) (Telephone) (Fax) (Email)

(Address) (City) (State) (Zip)

INFORMATION REQUESTED: I hereby authorize Center for Women's Health (CFWH) to release or disclose to the person(s) or organization listed, all medical records requested, including any specially protected records such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, or sexually transmitted infections (STI), unless otherwise noted. This authorization is valid for 12 months from the date of signature. I understand I may cancel this request with written notification; however, it will not affect any information released prior to the notification cancellation. I understand the information used or disclosed may be subject to re-disclosure by the recipient listed above and will no longer be protected by federal regulations. I understand I can refuse to sign this authorization, and my healthcare provider may not condition treatment on my signing this authorization.

ALL medical records without exception, including clinical notes, lab testing (including HIV), mental health treatment, alcohol or drug abuse testing & treatment, sexually transmitted disease, consultations, secondary records, etc. or:

PARTIAL medical records which may include HIV testing & treatment, mental health treatment, alcohol or drug abuse testing & treatment, sexually transmitted disease & other sensitive information. Please specify parts and dates to be released:

- | | | |
|--|---|---|
| <input type="checkbox"/> Office/Clinic Notes | <input type="checkbox"/> X-Ray/Ultrasound Reports | <input type="checkbox"/> Psychological/Psychiatric, if any |
| <input type="checkbox"/> Operative Notes | <input type="checkbox"/> Immunizations | <input type="checkbox"/> Lab/Pathology Reports <input type="checkbox"/> Gyn Records |
| <input type="checkbox"/> Physical | <input type="checkbox"/> Consultations | <input type="checkbox"/> Substance Abuse, if any |
| <input type="checkbox"/> Last 2 years of Records | <input type="checkbox"/> Dates _____ to _____ | |
| <input type="checkbox"/> Other (specify) _____ | | |

(If you do not want certain portions of your medical records released, please check the categories list below:)

- Substance Abuse, if Any AIDS/HIV/STIs, if any Psychological/Psychiatric conditions, if any

PURPOSE OF DISCLOSURE: Why are we sending the records?

- Personal Use Litigation/Legal Insurance Continuation of Care Transfer Care

DELIVERY METHOD: How would you like the records sent? Email Fax Postage (additional fee)

I authorize the release of my medical records as indicated above.

(Signature of Patient or Legal Guardian)

(Social Security Number)

(Printed Name)

(Date of Birth)

(Address)

(City, State Zip)

(Telephone Number)

(Date)

(Previous name under which records may be found)

(Witness) (Date)