CAPITAL WOMEN'S CARE
Working Together for Women's Health

AUTHORIZATION TO RELEASE PATIENT MEDICAL INFORMATION
FROM **CAPITAL WOMEN'S CARE**

Patient Name:_____ Acct. No#._____

Former Name (if any)_____ SS. No#._____

Daytime Telephone _____ Birth date_____/_____/_____ email

_____

INFORMATION TO BE RELEASED FROM:
I hereby authorize Capital Women's Care (CWC) to use and disclose my individually identifiable Protected Health Information (PHI) in the manner described below. I understand that my PHI may be redisclosed by the person or entity receiving my PHI from CWC, and that it then may no longer be protected by federal privacy regulations. State law may or may not prohibit such redisclosure by the person or entity receiving my PHI from CWC. I voluntarily sign this authorization, and I understand that my health care will not be affected if I do not sign this form. I understand that Capital Women's Care reserves the right according to their HIPAA Practicing Guidelines to use a third party vendor (Universata or Smart Corporation) to process / copy medical records containing PHI - information. Not all Capital Women's Care practices use this method for copying records release.

PROTECTED HEALTH INFORMATION TO BE RELEASED TO:
Name of Organization Street Address City/State/Zip

_____
_____

Purpose or need for this information is:
_____

TYPE OF INFORMATION TO BE RELEASED:
1. GENERAL RELEASE:
Type of Record
___ Medical Records/Excluding Protected Records
(This will be limited to 2 years of information including x-ray, Lab reports unless otherwise stated).
___ Lab Results (specify) _____
___ X-ray Reports (specify) _____
___ Surgical records (specify) _____
___ Other Records (specify) _____

2. INFORMATION PROTECTED BY STATE/FEDERAL LAW:
___ Drug Abuse Diagnosis/Treatment (specify) _____
___ Alcoholism Diagnosis/Treatment (specify) _____
___ Mental Health Diagnosis/Treatment (specify) _____
___ Sexually Transmitted Disease (specify) _____
Diagnosis/Treatment or Counseling (includes Aids/HIV) (specify) _____

I understand that I have the right to receive a copy of this authorization. I also understand this authorization is valid for 90 days only and may be revoked in writing at any time prior by notifying Capital Women's Care in writing. I understand I have the right to revoke the authorization at any time except to the extent that action has been taken in reliance thereon.

PATIENT AUTHORIZATION TO RELEASE MEDICAL INFORMATION
I certify that I have read, signed and received a copy of this authorization upon my request. I understand I will be billed for copies of my medical record according to HIPAA State of Maryland and Federal law.

_____ X_____
_____
Date Signature of Patient/ Legally Responsible Party Relationship to Patient if not Patient

CWC Use only: Total Fee:_____ Internal Processing :_____ External Processing_____

Date Received Request:_____ Date Mailed/Faxed/Patient picked up from Office_____ 7/2016