Affinity
Women's Health Care
Dr. Susan Catt OB/Gyn
Lindsey Fritz, APN

AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION

Patient Name:_____ Phone No.:_____

Patient Address:_____

Date of Birth:_____ Medical Chart No.:_____

Purpose of copying records: ☐ Transfer of care

☐ Referral to specialist

☐ Other:_____

Reason for Transfer:_____

I authorize *Affinity Women's Health Care* (circle one) to release information to / obtain information from:

Practice Name:_____

Practice Address:_____

Street City State Zip Code

Practice Phone No.:_____ Practice Fax No.:_____

Information to be disclosed:

☐ History & Physical ☐ Progress Notes ☐ Labs ☐ X-Rays/Imaging

☐ Operative Reports ☐ Other:_____

HIGHLY CONFIDENTIAL information to be disclosed:

☐ HIV/AIDS related health information ☐ Behavioral or mental health information

☐ Drug/Alcohol diagnosis, treatment, referral information ☐ Genetic testing information

I understand:

- That I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. In the even I refuse to authorize the release of the above-described information, I understand that it will not be disclosed, except as provided by law.
- That the practice may not condition treatment on whether I sign this authorization, except when the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.
- That information used or disclosed pursuant to this authorization may subject to redisclosure by the recipient and may no longer be protected by law.
- That this authorization is valid until it expires, unless revoked before the date provided.
- That I may revoke this authorization at any time by giving a dated written notice of my desire to do so to the physician. I also understand that I will not be able to revoke this authorization in cases where the physician has already relied on it to use or disclose my health information. A dated written revocation must be sent to the physician's office.
- That I have read and understand the terms of the authorization and I have had the opportunity to ask questions about the use and disclosure(s) of my health information.
- There is a copy fee of $25.

By signing below, I knowingly and voluntarily authorize the disclosure of my protected health information as described above.

X_____ ___/___/_____

Printed Name of Patient, Legal Guardian, or Authorized Agent Date

X_____

Signature of Patient, Legal Guardian, or Authorized Agent

_____

Relationship to Patient

X_____

Witness Signature