Clinic for Women, P.A.
910 Adams Street, Suite 300 Huntsville, AL 35801
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Phone – (256) 533-7420 Fax – (256) 536-4109

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Authorization for Release / Request of Protected Health Information

Patient's Name: _____ Date of Birth: _____

Address: _____

City/State/Zip Code: _____

SS#: _____ Patient's Phone #: ( ) _____

Date of Request: _____ Date Needed: _____

☐ I authorize The Clinic for Women to release information to:

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone # / Fax # (Include Area Code)

OR

☐ I authorize The Clinic for Women to obtain information from:

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone # / Fax # (Include Area Code)

Purpose For This Request: (Check one) ☐ Healthcare ☐ Insurance Coverage ☐ Personal ☐ Other

Type of Records Requested: (Check One)

☐ Specific Information (Select one or more, as applicable)

- ☐ Operative report
- ☐ Laboratory Test Results
- ☐ Office Notes
- ☐ History & Physical
- ☐ X-Ray Reports
- ☐ DEXA Results
- ☐ Consult
- ☐ Discharge Summary
- ☐ MMG
- ☐ Other: _____

☐ All medical records related to a specific illness or injury

_____
Specify Illness / Injury Date(s) of Treatment

I understand that:

- My right to healthcare treatment is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a *written* request to the address provided at the top of this form, expect where a disclosure has already been made in reliance on my prior authorization
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be re-disclosed.
- Release of HIV-related information, mental health related care, or substance abuse diagnosis and treatment information requires additional authorization.
- Expiration Date

NOTE: Medical Records are faxed in cases of medical necessity only.

Signature of Patient: _____ Date: _____

Witness: _____

Date Mailed: _____