

# Comprehensive Healthcare for Women

1687 Woodlane Drive Suite 101, Woodbury, MN 55125

Phone # 651-209-6263 Fax # 651-209-6264

## AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name \_\_\_\_\_ Provider Name \_\_\_\_\_

Previous Name(s) \_\_\_\_\_ SS # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Home # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Work # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Cell # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

\_\_\_\_ This will authorize Comprehensive Healthcare for Women to request information **FROM:**

\_\_\_\_ This will authorize Comprehensive Healthcare for Women to release records **TO:**

Name/Organization _____			
Address _____			
City _____	State _____	Zip Code _____	
Phone # _____ - _____ - _____	Fax # _____ - _____ - _____		

### Please choose from the following information to be released: (please circle items needed)

All GYN Records	Radiology Reports	ER Reports	Mammogram
All OB Records	Laboratory Reports	Pathology Reports	Colonoscopy
Progress Notes	History and Physical	Immunizations	Pap Smears
Operative Notes	Other _____		

For the following date(s) of treatment or condition: \_\_\_\_\_

### I am requesting this information for use by: (please circle)

Medical Personnel/Facility	Insurance Company	Personal Use	Attorney
Worker's Compensation	Other _____		Transferring Care

### Please indicate your reason for the transfer: (please circle)

Moving      Insurance Change      Dissatisfaction      Primary Physician      Convenience of location

- All records pertaining to psychiatric/mental health, chemical dependency and/or AIDS/HIV related illness/testing **will be released unless initialed here** \_\_\_\_\_. Please indicate specific restrictions. \_\_\_\_\_
- I understand I may revoke this authorization by written request at any time. 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 as law provides my insurer with the right to contest a claim under my policy.
- This authorization will **automatically expire one year from the date of my signature** unless I indicate an earlier date here \_\_\_\_/\_\_\_\_/\_\_\_\_.
- I understand that I may refuse to sign this authorization. I need not sign this authorization to ensure treatment.
- I understand there **will be a retrieval/copy charge for medical information requested that's older than 3 years from this release.**
- I understand that once information is released pursuant of this authorization, Comprehensive Healthcare for Women cannot prevent the re-disclosure of that information to any third party.
- **I understand this authorization must be filled out completely and signed in order to be consider valid.** A copy that has not been altered will be considered as valid as an original.

\_\_\_\_\_  
Signature of Patient/Authorized Person

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date

REASON PATIENT IS UNABLE TO SIGN:    Minor    Deceased    Other: \_\_\_\_\_