

**Women's Health Alliance p/k/a
Atrium ObGYN
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

(Print patient's full name)	Birth date (Mo/Day/Yr)
(Street address)	Social security number
(City, state, zip code)	Phone (Home)

At the request of the individual, I _____, do hereby authorize Atrium ObGyn to release:
(patient's name)

_____ DISCHARGE SUMMARY	_____ PATHOLOGY REPORTS	_____ EMERGENCY REPORTS
_____ HISTORY & PHYSICAL	_____ LABORATORY REPORTS	
_____ PROGRESS NOTES	_____ RADIOLOGY REPORTS	
_____ OPERATIVE NOTES	_____ ECG/EEG/CARDIC CATH	_____ OTHER _____

From the time period of _____ to _____
I do _____ I do NOT authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

INFORMATION RELEASE TO:

Name of Company/Agency/Facility/Person
Street address
City, state, zip
Phone number

PURPOSE OF DISCLOSURE:

_____ REFERRAL TO SPECIALIST	_____ INSURANCE	_____ WORKERS COMP	_____ CHANGE OF DOCTOR
_____ LEGAL INVESTIGATION	_____ DISABILITY DETERMINATION	_____ PERSONAL	_____ CONTINUING CARE

OTHER (SPECIFY) _____

Please provide current daytime telephone number in the event we need to contact you:

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not effect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized is furnished may not condition its treatment of me on whether or not I sign the authorization.

Signature of individual or guardian or personal representative of patient's estate	Date
--	------

PLEASE NOTE: THERE IS A CHARGE FOR MEDICAL RECORDS WHEN REQUESTED FOR PERSONAL REASONS OR PERMANENT TRANSFER. SMART CORPORATION HAS BEEN CONTRACTED TO PROVIDE THIS SERVICE AND WILL INVOICE YOU DIRECTLY.

MEDICAL INFORMATION RELEASED BY SMART CORPORATION

ENTIRE _____	LAB _____	EKG _____	_____
DS _____	EKG _____	IMMUNE _____	ROI SPECIALIST _____
OP _____	X-Ray _____	CLINIC _____	DATE _____
HP _____	PATH _____	OTHER _____	NUMBER OF PAGES _____