ISLAND WOMEN'S CARE, LLC

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INFORMED AUTHORIZATION AND CONSENT FOR THE RELEASE OF MEDICAL RECORDS

I hereby authorize *ISLAND WOMEN'S CARE, LLC* to release and/or obtain medical records for:

____ DOB: ________________
(PRINT VERY CLEARLY PATIENT'S NAME)

( ) RELEASE TO

____
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____

( ) OBTAIN FROM

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FOR THE PURPOSE OF <u>CONTINUITY OF CARE</u>

INFORMATION TO BE DISCLOSED:
( ) Medical Notes/Summary ( ) Operative/Procedure Reports ( ) Annual visit

( ) PAP/HPV Type ( ) Mammogram Report ( ) Pelvic U/S ( ) Bone Density

( ) Recent Labs ( ) Pathology ( ) Last 2 years of documentation ( ) ________________

I UNDERSTAND THAT THESE MEDICAL RECORDS MAY OR MAY NOT CONTAIN INFORMATION PERTAINING TO PSYCHIATRIC COUNSELING OR TESTING, ALCOHOL OR DRUG ABUSE COUNSELING OR TESTING, AND/OR HIV/ARC TESTING. I DO EXPRESSLY AND VOLUNTARILY AUTHORIZE THE DISCLOSURE OF THE SAID MEDICAL RECORDS TO THE PERSON(S) AND/OR ENTITIES AS STATED ABOVE. I UNDERSTAND THAT INFORMATION DISCLOSED PURSUANT TO THIS AUTHORIZATION MAY BE SUBJECT TO REDISCLOSURE BY THE RECIPIENT AND MAY NO LONGER BE PROTECTED BY FEDERAL OR STATE PRIVACY LAWS. THIS AUTHORIZATION/CONSENT WILL REMAIN IN EFFECT FOR A PERIOD OF ONE YEAR FROM THE DATE OF SERVICE STATED BELOW, UNLESS OTHERWISE REVOKED IN WRITING BY THE PERSON TO WHICH IT PERTAINS.

____ DATE: __________________
(SIGNATURE OF PATIENT, PARENT, LEGAL GUARDIAN OR LEGALLY AUTHORIZED AGENT)