Women's Wellness
AT FLOWER MOUND

Patient Authorization to Disclose Protected Health Information

Patient Name	Date of Birth	Last 4 of Social Security Number
Address	**City, State, Zip Code**	**Telephone Number**

I hereby authorize the facility listed below to disclose/release the Protected Health Information specified in this request to the organization, agency or patient named.

Release by: Women's Wellness at Flower Mound
Facility
3051 Churchill Dr., Ste. 220
Address
Flower Mound, TX 75022
City, State, Zip Code
P+972.355.9436 F+214.513.2244
HIM Phone/Fax Numbers

Release to:
Organization, Agency, Individual
Attn:
Address
City, State, Zip Code

Treatment Date(s):

Purpose: ☐ Further Medical Care ☐ Workers' Comp
☒ Personal Use ☐ Insurance ☒ Legal
☐ Marketing/Fundraising
☐ Other:

Type of Disclosure Authorized & Delivery Instructions:
☐ Provide copies of records to organization/agency/individual
☒ Mail records directly to address above
☐ Call to pick-up records:
☐ Fax records to:

Pertinent Protected Health Information Allowed to be Included:

☐ Discharge Summary	☐ Radiology	☐ Special Studies	☐ Entire Medical Record
☒ History & Physical/Consult	☒ Outpt Record	☐ Medication Records	
☐ Operative Report	☐ Progress Notes	☐ Psych Health Records	
☒ Labs	☐ Physician Orders	☐ Other (specify):	

Psychotherapy Notes are distinct and may not be included with the disclosure of any other protected health information. A Patient Authorization to Disclose Psychotherapy Notes must be completed.

Authorization: I certify that this request is made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time in writing by submitting my request in writing to the designated Health Information Management / Medical Records department. If I have authorized the disclosure of my health information to someone who is not legally required to keep it private, it may be re-disclosed and may no longer be protected. A copy or fax of this authorization will be as valid as the original.
I understand that authorizing disclosure of health information is voluntary. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or my eligibility to obtain benefits. I understand that I may inspect or obtain a copy of the information to be disclosed. I understand a fee may be charged for copies of my medical record. I understand the facility will provide me a copy of the signed authorization form. If I have questions about disclosure of my health information, I can contact the designated Corporate Responsibility and Privacy Officer.
Expiration: Without my express revocation, this authorization will automatically expire upon satisfaction of the need for disclosure, but in any event will expire 90 days from the date hereof, unless a different date is specified here:
Acknowledgement: I understand that the information to be disclosed may include any or all information involving communicable or venereal disease, psychological or psychiatric conditions, drug or alcohol abuse and/or alcoholism. It may also include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea and human immunodeficiency viruses (HIV), also known as acquired immune deficiency syndrome (AIDS).
For Marketing/Fundraising Purposes Only, if applicable: I understand that Centura Health ☐ will ☐ will not receive remuneration, either direct or indirect, as a result of the marketing that I hereby authorize.

SIGNATURE: _____ **DATE:**
Patient (Parent or Legal Guardian)

Minor's signature is required for release of any records for treatment which the minor may authorize under Colorado Law.

Relationship (if other than patient): _____ ☐ Power of Attorney ☐ Death Certificate

Name of individual signing on behalf of patient: _____

Verification: ☐ Drivers License # _____ ☐ Other Appropriate ID: _____

OFFICE USE ONLY: Attach copies of required identification.

Number of pages released: _____ Completion date: _____ Delivery method: _____
Name of individual who received request: _____ Date received: _____
Patient Medical Record Number / Account Number: _____ / _____