**PHYSICIANS FOR WOMEN P.C.**
880 Eastport Centre Drive, Suite 200
Valparaiso, IN 46383
Phone 219-464-0409 Fax 219-464-2376

# AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

(This authorization complies with the requirements of HIPAA)

1. I hereby authorize _____ to release health information as described below for the purpose of:

_____Second Opinion _____Personal Files
_____Transfer To New Physician _____Other:_____

2. Patient Name: _____ Birth Date: _____
Address:_____

3. I authorize the following information to be released from my medical records (NOTE: the records are to include records received from other health care providers):
(**Please indicate the appropriate item by checking line OR completely cross out that which does not apply)**

_____Entire Office Chart _____History & Physical _____Operative Reports
_____Progress Notes _____Discharge Summary _____Laboratory Reports
_____Pathology Reports _____Itemized Bills _____X-Ray Reports
_____Consultation Reports _____Other: _____
From Date:_____ To Date: _____

4. I understand that the information in my health records may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

5. This information may be disclosed to and used by the following individual organization with address below:
_____
_____

6. I understand that I may revoke this request at any time in writing. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Physicians For Women. 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 when the law provides my insurer with the right to contest a claim under my policy. This request shall remain valid until revoked or upon the expiration of sixty (60) days, whichever occurs first.

7. I understand that signing this authorization is a voluntary act. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I further understand that I may inspect or copy the information to be used or disclosed, as provided in C.F.R. 164.524. I also understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the management staff at Physicians For Women, at 219-464-0409.

8. I understand there is a fee for copying these records in accordance with Indiana Code 16-39-9-3.

☐$15 Retrieval Charge ☐$0.25/Additional page after 10 pages if retrieval fee charged
___pages x $0.25 = _____
☐$10.00 Received copies within 2 working days ☐ _____Actual Postage Costs
Amount Due: _____
Date Paid: _____ ☐Cash ☐Check____ ☐Credit Card____ Amount Paid: _____

9. A photocopy of the authorization shall have equal standing and import as if it were an original.

Date:_____ Signature: _____