The Whole Woman, PLLC

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Patient Name: ____ DOB:___________________________________

Street Address:____

City, State, Zip:____ Phone:__________________________________

I hereby authorize the release of information to The Whole Woman from:

Name:____

Address:____

City, State, Zip:____

Phone:___________________________ Fax:______________________________

For the purpose of:
___ Continued treatment ___ Legal review ___ Insurance purposes ____ Collaboration of care

___ Other (please describe) ____

Records are for (specify dates and records requested):____

1. I understand that this authorization will expire six months from this date. A photocopy of this form will be considered as valid as the original.
2. I understand that this health information may include HIV-related information, mental health, alcohol, drug, sexually transmitted diseases, information relating to pregnancies and/or information relating to cancer diagnosis.
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specially protected information such as substance abuse treatment information, HIV/AIDS related information and psychiatric/mental health information. I understand that I may revoke this authorization at any time except to the extent that the information has already been released pursuant to this authorization and before I have revoked my authorization.

By signing below, I acknowledge that I have read and understand this authorization.

____ OR ____

Signature of Patient — Parent/Legal Guardian/Authorized Person

Date:____