aventa
specialized women's care

Authorization *for Release of Information*

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I hereby authorize the use of disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, then the released information may be no longer be protected by federal regulations.

Patient _____ Date of Birth _____

Social Security Number _____

Person/Organization Providing Information _____

Person/Organization Receiving Information _____

Specific description of information: **All Medical Records** ❑ **Labs** **Date Range** _____ **to** _____

What is the purpose of the use or disclosure: **Continuation of Care** ❑ **Test** ❑ **Office Notes** ❑ **Surgical**

Other: _____

I understand that this authorization will expire 6 months from the date signed.

I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it will not have any effect on actions they took before they received the revocation.

Signature of Patient or Guardian _____ Date _____

Printed name of Patient or Guardian _____ Relationship _____

This medical record may contain information about drug abuse, alcoholism, alcohol abuse, venereal disease, abortion, HIV testing and/or AIDS diagnosis treatment. Separate consent must be given before this information can be released.

I do consent to have this information released _____

I do not consent to have this information released _____

Signature of Patient or Guardian _____ Date _____

Printed name of Patient or Guardian _____ Relationship _____

Home Phone Number _____ Cell Phone Number _____

E-mail Address _____