Authorization for Release of Protected Health Information

Patient's Name:________________________________ DOB:_____________

Date of Request:___________ Date Needed:____________

I authorize the Alabama Women's Wellness Center, P.C. to **send records to** / **request records from:**

____
Name or Provider or Facility

____
Street Address

____
City/State/Zip

Ph:______________ / Fx:____________

612 Madison St. SE
Huntsville, Alabama 35801
ph: (256) 763-0036
fx: (855) 533-2113

Type of record requested:

___ Laboratory Test Results | ___Office Notes | ___Operative Reports

___ All Medical Records From _____ to _____ (mm/dd/yy)

___ Other_______________________

Authorized to Pick-up/Deliver:

____

I do not have to sign this authorization in order to receive treatment from AWWC, P.C.; In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My Written Revocation must be submitted to the Privacy Officer at: AWWC, P.C., attention Privacy Officer, 612 Madison Street, Huntsville, Alabama 35801.

____
Signature of Patient or Legal Representative Date

____
If signed by Legal Representative, relationship to Patient Date

____
Witness Date

For Office Use Only: Completion Date: _____________ Initial: ______

__Faxed __Picked up by Patient __Mailed by AWWC