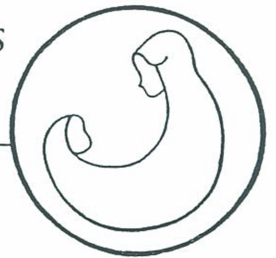
Women's Health, Inc.

Alan Binette, M.D.

DBA: Women's Specialty Group



AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name:____ DOB:__________________

I authorize my records to be released from:

____
Name of Clinic/Physician

____
Mailing Address

____
City State Zip Code

(_____)________________ (_____)____________
Phone Fax

Please send my records to:

____
Name of Clinic/Physician

____
Mailing Address

____
City State Zip Code

(_____)________________ (_____)____________
Phone Fax

PURPOSE OF THE RELEASE: (please check one) _____Changing OB/GYN Physician

___Changing Primary Care Physician ___Insurance ___Legal ____Referral/Consult ____Other

TYPE OF INFORMATION TO BE RELEASED - (please INITIAL)

______ All Medical Records ______ Chart/Office Notes _______ Surgical/Operative Reports

______ Laboratory Reports ______ X-ray/Study Reports _______ Hospital Records

______ Pathology Reports ______ Other____

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.

______HIV/AIDS information ______Mental health information _______Genetic testing

______Alcohol/chemical dependency information ______ Sexually transmitted disease information

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal law restricts re-disclosure of alcohol/chemical dependency diagnosis, treatment or referral information and specifically requires my authorization prior to re-disclosure.

____
SIGNATURE/AUTHORIZATION TO RELEASE INFORMATION DATE

Authorization is valid for six months and may be revoked in writing at any time prior to six months.

OBSTETRICS • GYNECOLOGY • INFERTILITY

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