SNE WOMEN'S HEALTH

AUTHORIZATION TO RELEASE PROTECTED HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____ Telephone: _____

Address: _____
Street City Zip

I request and authorize SNE and Dr. _____

to release healthcare information of the patient named above to:

Name/Facility: _____

Address:_____
Street City Zip

Phone #: _____ Fax #: _____

This request and authorization applies to healthcare information relating to: (specify treatment, condition, or dates)

_____

This authorization is being requested for the following purpose(s) (initial all that apply)

____ Medical Care ____ Legal _____ Insurance ____ Personal

____ Other (please describe): _____

Authorization re: sensitive information: To the extent applicable, I understand that my medical record may contain information that is considered sensitive under the law. My check mark(s) below indicate(s) that I do **NOT** permit information of this type, if it exists, to be released. I understand that if I do not check the box, SNE Women's Health will release such information about me if it exists.

- ☐ HIV/AIDS
- ☐ Genetic Information
- ☐ Mental Health
- ☐ Sexually Transmitted Diseases
- ☐ Treatment for alcohol and/or drug abuse
- ☐ Psychotherapy Notes

I understand and acknowledge that:

- authorizing the release of the Patient's Health Information is voluntary;
- refusal to sign this authorization does not affect the Patient's treatment, payment of claims, health plan enrollment or eligibility of benefits;
- this authorization may be revoked at any time upon written request to the provider's office administrator or privacy officer except to the extent that the release of the Patient's Health information has already occurred in reliance on this authorization;
- unless previously revoked, this authorization will automatically expire six (6) months from the date of signature below;
- any information released to the recipient many be re-disclosed and may no longer be protected by federal or state privacy and or confidentiality laws.

_____
Signature of Patient or Legal Representative of Patient Date

_____
Print Name of Patient or Legal Representative of Patient Relationship to Patient or Authority to Act

_____
WITNESS Date