Health Care For Women
980 W Ironwood Dr Suite 101
Coeur d' Alene, ID 83814
Phone (208) 765-1455
Fax (208)667-2556

AUTHORIZATION TO USE AND/OR DISCLOSE MEDICAL RECORDS

Patient Name_____Date of Birth:_____

Address:_____

City/State:_____Zip:_____ Phone #:_____

I authorize Health Care for Women to **SEND** a copy of the specific health and medical information identified below TO THE FOLLOWING:
Name and address of recipient:_____
_____
_____
I authorize Health Care for Women to **RECEIVE** a copy of the specific health and medical information identified below FROM THE FOLLOWING:
Name and address of sender:_____
_____
_____

For the following purpose/s:_____
By initialing the spaces below, I specifically authorize the use and/or disclosure of the following health information and/or medical records, if such information and/or records exist:

_____Please send the entire medical record
_____Medical records needed for continuity of care
_____Clinician office chart notes
_____Laboratory reports
_____Pathology reports
_____Gyn records
_____OB records
_____other:_____
_____

The following items must be initialed to be included in the use and/or disclosure of other health information:
_____HIV/AIDS related information and/or records
_____Mental health information and/or records
_____Genetic testing information and/or records
_____Drug/alcohol diagnosis, treatment or referral information (federal regulations require a description of how much and what kind of information is to be disclosed)
Describe:_____

I understand that, if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I also understand that the person I am authorizing to use and/or disclose the information may receive compensation for doing so.

I further understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information to be used and/or disclosed under this authorization.

Finally, I understand that I may revoke this authorization in writing at any time, provided that I do so in writing, except to the extent that action has been taken in reliance upon this authorization. Unless revoked earlier, this authorization will expire 180 days from the date of signing.

_____ _____
Signature of Patient or legal representative Date

_____ _____
Print Patient's Name Print Name of Legal Rep./relationship to patient