

# Esprit Woman Care

9397 Crown Crest Blvd, Suite 320

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## AUTHORIZATION FOR RELEASE OF INFORMATION

### Patient Information (please print)

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Are you changing doctors?  YES  NO Phone Number: \_\_\_\_\_

### Physician/Facility to release/disclose records:

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### Health information may be released/disclosed to:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

### My rights:

I understand I do not have to sign this authorization in order to get health care treatment. I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the above named practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Once the office discloses health information, the person or organization that received it may re-disclose it. Privacy law may no longer protect it.

### My authorization:

This authorization ends in 90 days from the date signed. A copy of this authorization with my signature is as valid as the original. You may disclose the following health care information (check all that apply):

- One portion of records, specifically: \_\_\_\_\_
- Health information related to drug abuse, alcohol abuse or psychological/psychiatric conditions.
- HIV test results
- All other medical records generated by this facility.

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_