



COURI CENTER

—for Gynecology and Integrative Women's Health—

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I. Authorization for Release of Information

I, _____
Name of patient, parent, guardian, or authorized person

Authorize _____
Name and address of individual or organization to disclose records

To release to _____
Name of individual or organization to which disclosure is to be made

and/or _____

II. The Relevant Information from the Medical Record of:

Name of patient

Whose birth date is _____

And whose social security number is _____

This information is being requested for the purpose of _____

III. RECORDS TO BE DISCLOSED

For a complete release of records, please initial PART 1. For a partial release of records, note any exceptions in PART 2.

Part 1. _____ All medical records, **INCLUDING** records concerning any
Mental health and developmental disabilities, alcohol and
Drug abuse records and HIV testing

Part 2. _____ All medical records **EXCLUDING** information pertaining
To:

___mental health and developmental disabilities

___alcohol and drug abuse records

___HIV testing

Disclosure Information

I understand that my records are protected under law and cannot be disclosed without my written permission unless otherwise provided by statutes or regulations. I have the right to revoke this consent by written statement at any time prior to release. I understand that I have the right to inspect and copy the information to be disclosed although in certain instances applicable states or regulation may place restrictions on the right. No information released shall be disclosed again to other individuals or agencies. This consent expires on the _____ day of _____, 20____, unless earlier or revoked by me in writing.

Patient's Signature: _____
(If patient is unable to sign, state reason and relationship of person signing)

Date: _____

Parent/ Legal Guardian: _____
(State relationship to patient and legal basis on which consent is given)

Date: _____