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 from

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

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 statues 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: _____ ***Date***: _____
(If patient is unable to sign, state reason and relationship of person signing)

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