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)