WOMEN'S HEALTH CARE OF WESTERN COLORADO, P.C.
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AUTHORIZATION TO USE OR DISCLOSE HEALTH CARE INFORMATION

1. Patient Information (required)

Patient Name:	SSN:
Previous Name:	Date of Birth:

2. Health Information to be Disclosed or Omitted:

Check all that apply: (NOTE) OB/GYN Medical Records include any of the below conditions. Please specify if you DO NOT wish to have any part of the below records disclosed :

- HIV (AIDS Virus) Yes □ No □
- Sexually Transmitted diseases Yes □ No □
- Psychiatric disorders/mental health. Yes □ No □
- Drug and/or alcohol use Yes □ No □

3. Health Information Period for Disclosure (Required)

You may use or disclose health care information for the following date(s) check one:

- □ Most Recent pertinent information
- □ Prior two years only
- □ Other:

4. Health information to be released From:

Organization/Person:_____ Physician:_____

Address: _____ City: _____ State: _____ ZIP: _____

Telephone/Cell: (____) _____ (____) _____ Fax (____) _____

5. Health Information to be sent to:

Organization/Person:_____ Physician:_____

Address: _____ City: _____ _____ State: _____ ZIP: _____

Telephone/Cell: (____) _____ (____) _____ Fax (____) _____

6. Reason for this Authorization (required):

I hereby authorized Women's Health Care of Western Colorado (WHC) to discuss and release all related patient health information for the following purposes: Check one. □ Medical Care □ Legal □ Insurance/Billing □ Marketing/Fund Raising □ Other

(Note) WHC reserves the right to charge a copy fee

7. Authorization Expiration:

Unless revoked by me in writing, I understand that this authorization will expire one (1) year from the date of my signature below.

8. My Revocation Rights:

I understand that I have a right to revoke this authorization in writing at any time by filling out a revocation form at WHC or by writing a letter to WHC; however, I also understand that the revocation may not apply when WHC has:

- Already taken action based upon this authorization; or,
- Where authorization was required for my insurance coverage.

9. My Rights:

I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment): however;, I do have to sign an authorization form to:

- Take part in a research study
- To receive health care when the purpose is to create health care information for a third party

_____ / / AM/PM

Patient or legally authorized individual signature (required) Date: Time:

_____ _____

Printed name if signed on behalf of the patient (required) Relationship (required) Parent/Legal Guardian/Personal Rep.