Women's Health
Associates

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name: _____ Maiden Name: _____
Address: _____
_____
Phone: ( ) _____ Date of Birth _____/_____/_____

I authorize my medical records to be released:

TO/FROM (circle one):
Women's Health Associates
333 N. First Street, Suite 240
Boise, ID 83702
Phone: (208) 338-8900
Fax: (208) 429-1350
appointments@womenshealthboise.com

TO/FROM (circle one):
Name: _____
_____
Address: _____
_____
Phone: ( ) _____
Fax: ( ) _____

Purpose for the medical records release: _____
This authorization will expire on the following date or event: _____.
If I fail to specify an expiration date or event this authorization will expire 1 year from the date signed.

The following information is authorized for release:

- ☐ All records
- ☐ Recent Visit/Notes
- ☐ Radiology Reports
- ☐ Other: _____
- ☐ Operative Reports
- ☐ Pathology Reports
- ☐ Laboratory Reports

I understand the information in my health record may include information relating to substance abuse, mental health information, human immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS) and sexually transmitted disease. My signature below authorizes release of all such information.

I understand that the information disclosed by this authorization could be re-disclosed by the person receiving it and is no longer protected by federal or state legal privacy requirement. Women's Health Associates, PLLC, its affiliates, its employees and officers are not legally responsible or liable for the re-disclosure of the information indicated on this authorization. I know I may revoke this authorization to the extent that it has not already been relied upon. I may revoke this authorization by writing a statement that I withdraw my authorization for further release of my records. I understand that the disclosure of this health information is voluntary. I do not need to sign this form to assure treatment unless the sole purpose of the treatment/examination/evaluation is to provide information to a third party. I have a right to receive a copy of this authorization.

Patient or patient representative: _____ Date: ____/____/____
If not patient, relationship to patient: _____
Printed name of patient representative: _____