Center for Women's Health
SALISBURY
Healthcare Every Woman Deserves

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# Outside Record Release or Disclosure of Health Information

***Please print clearly***

Patient Name:_____ Telephone:_____

Date of Birth:_____ Social Security Number: _____

Address:_____

| | Records to be Released From: | Records to be Released To: |
|---|---|---|
| Name: | | |
| | | |
| Address: | | |
| Telephone: | | |
| Fax: | | |

**Please send only the information checked below. Circle N/A if not available.**

- ☐ ENTIRE CHART
- ☐ LAST OFFICE NOTE (N/A)
- ☐ ALL TESTING FROM PAST 2 YEARS (N/A)
- ☐ ALL LABS (N/A)
- ☐ ALL IMAGING (N/A)
- ☐ ALL OPERATIVE AND PATHOLOGY REPORTS (including pre-op, post-op, and discharge notes) (N/A)
- ☐ Other _____

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment. I give my authorization for these records to be released unless specifically excluded. My initials below indicate records EXCLUDED from this authorization. The following information is NOT authorized for release:

- ☐ Drug/alcohol abuse/treatment and diagnosis
- ☐ HIV/AIDS diagnosis/treatment/testing
- ☐ Sexually Transmitted Disease
- ☐ Mental Illness or psychiatric diagnosis/treatment

I understand I do not have to sign this authorization in order to obtain healthcare benefits (treatment, payment or enrollment) and that I may revoke this authorization in writing at any time except to the extent action has been taken in reliance on this authorization. I understand that the information authorized for disclosure (except drug and alcohol treatment records) ay be subject to re-disclosure by the recipient listed above, at which time it may no longer be protected under federal HIPAA Privacy Rules.

Patient Signature:_____ Date:_____

**This authorization will expire in 90 days**