Evergreen Women's Care, PLLC
Authorization to Release Healthcare Information

Patient Name: ______________________________ **DOB:** ________________________

Previous Names: ______________________________ **SSN:** ______________________

I request and authorize: To:

Provider to release information:	New Provider/Organization
Name:	Name:
Address:	Address:
Phone:	Phone:
Fax:	Fax:

Reason for requesting medical records:
☐ To take to another healthcare provider ☐ To send to insurance ☐ Legal purposes ☐ Personal

☐Other (specify use): ____

Please release the following information:

☐ The most recent two (2) years of pertinent information
☐ All healthcare information
☐ Healthcare information relating to the following treatment or condition: ________________________
☐ Healthcare information limited to the following dates: ______________________________________
☐ DO NOT RELEASE THE FOLLOWING INFORMATION: _______________________________

Patient Authorization
I understand that my express consent is required to release any healthcare information relating to testing, diagnosis and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. I understand that this authorization, unless specifically limited by me in writing above, will extend to all aspects of treatment, including testing and/or treatment for HIV (AIDS virus), sexually transmitted diseases, drug and/or alcohol treatment, and mental or psychiatric treatment.
I may cancel this authorization in writing as allowed by law. This would not affect any actions already taken based upon my original request. There are three ways to cancel this authorization:

- Sign and date a revocation form
- Write, sign and date a letter to Evergreen women's care to cancel the authorization; or
- Sign, date and write "CANCEL" on this original form.

Once Evergreen Women's Care releases information based on this authorization, Evergreen Women's Care no longer has control over its use. There is potential for redisclosure of the PHI and thus, no longer protected by Evergreen Women's Care privacy policies.

______________________________ ______________________ ______________________
Patient or legally authorized individual signature Date Time

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Relationship if signed on behalf of patient (parent, legal guardian, etc)

This authorization will expire 90 days after the date it is signed
Please allow 14 business days for processing **Copying fee may apply**