AUTHORIZATION TO RELEASE INFORMATION TO ANOTHER DOCTOR/FACILITY

Patient Name: ______________________________ **Date of Birth:**________________________
(PLEASE PRINT)

Social Security/Medical Record Number:_________________________________

1. I authorize use or disclosure of the above named patient's information as described below.

2. The following individual or organization is authorized to make the disclosure:

Better Women's Care
29425 Northwestern Highway #200, Southfield, MI 48034
Phone: (248) 948-6900 Fax: (248) 948-6904
Email: betterwomenscare@gmail.com

3. Specific type of information to be disclosed **(CHECK ALL THAT APPLY)**:

__ Entire Record
__ Problem List
__ Medication List
__ History & Physical
__ Other (please specify) ____
__ Lab Reports
__ Ultrasound Reports
__ Visit Notes
__ Immunization Records
__ Consultation Reports

I understand that the information contained in my patient record may include information about alcohol and drug abuse, behavioral or mental health and infections including, but not limited to sexually transmitted diseases, AIDS related complex, HIV, Hepatitis or TB.

4. The information may be used or disclosed to the following individual or organization **(PLEASE PRINT):**

Name: ____

Address: ____

Phone# ___________________________________ **Fax #** ___________________________________

5. The purpose of and need for this disclosure is **(CHECK ONE)**:
__ Continuation of healthcare
__ Personal record
__ Other (please specify) ____

6. I have the right to revoke this authorization except to the extent that Better Women's Care has acted in reliance upon this authorization. The cancellation of this authorization must be in writing. Unless I specify differently, this authorization will expire in ninety (90) days.

7. I understand that when my information is disclosed, it may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy laws and regulations.

____ ________________________________
Signature of patient or legal representative Date

____ ________________________________
Print name & relationship to patient Signature of witness