

AUTHORIZATION TO RELEASE INFORMATION TO BETTER WOMEN'S CARE

Patient Name: _____
(PLEASE PRINT)

Date of Birth: _____

Social Security/Medical Record Number: _____

- I authorize use or disclosure of the above named patient's information as described below.
- The following individual or organization is authorized to make the disclosure **(PLEASE PRINT)**:

Name: _____
 Address: _____
 Phone # _____ Fax# _____

- 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.

- The information may be used or disclosed to the following individual or organization:

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

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