AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

THE CENTER FOR REPRODUCTIVE HEALTH
508 W. 6th Avenue, Suite 500, Spokane WA 99204 (509) 462-7070 Fax (509) 462-7071
Edwin D. Robins, MD ◆ Debbie Little, ARNP

Patient's name: _____ Date of birth: _____

Previous name: _____ SSN: _____

Daytime phone: _____ Date records needed by: _____

I request and authorize (physician's name here):	**to release health care information as indicated below to**:
Name: _____ Address: _____ _____ Phone: (_____)_____ Fax: (_____)_____	**The Center For Reproductive Health** 508 W. 6th Avenue, Suite 500 Spokane WA 99204 (509) 462-7070 Fax (509) 462-7071

Please indicate what information is to be released by checking the appropriate boxes:

☐ ***One (1) year of complete medical records <u>including</u>*** any of the information regarding sexually transmitted disease, reproductive health, drug and alcohol history, mental health/physical abuse and HIV/AIDS information.

---OR ---

***Specific information as checked below*:**	***I specifically authorize the release of information relating to*:**
☐ Operative Notes/Pathology Reports	☐ Sexually transmitted disease
☐ Progress Notes	☐ Substance abuse (including alcohol/drug abuse)
☐ Lab/X-ray Reports	☐ Mental health
☐ HSG Films	☐ Physical Abuse
☐ Other: _____	☐ HIV related information (AIDS related testing)

PURPOSE OF DISCLOSURE:

☐ Changing physicians ☐ Consultation/second opinion ☐ Continuing care ☐ Legal
☐ School ☐ Insurance ☐ Workers Compensation
☐ Other (please specify): _____

This authorization expires **90 days** after the date it is signed. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.

_____
Signature of Patient or Patient's Authorized Representative **Date signed**

_____
Relationship or status if signed by anyone other than patient (parent, legal guardian, personal representative, etc.)

Consent of a Minor: A minor patient's signature alone is required in order to release information concerning care for: (1) conditions relating to the minor's sexuality including, but not limited to reproductive health, sexually transmitted diseases (age 14 and above), (2) alcoholism and/or drug abuse (age 13 and above), (3) mental health conditions (age 13 and above).

_____
Signature of Minor Patient **Date signed**