WOMEN'S HEALTH ASSOCIATES, PLLC

PATIENT AUTHORIZATION FORM

Patient Name:_____ Date of Birth:_____

Maiden Name:_____ Phone Number:_____

Address:_____

_____

I authorize that my medical information be released:

***Please Circle:* To or FROM**

Physician's Name:_____

Women's Health Associates
333 N. First Street, Suite 240
Boise, Idaho 83702

(208) 338-8900 Phone
(208) 344-0810 Fax

***Please Circle:* To or FROM**

Physician's Name:_____

Address:_____

Phone & Fax:_____

Purpose for Medical Records Release:_____

This consent will expire ONE YEAR after the date it is signed, or sooner at my written request.

Copies of records requested:

_____ Previous Visit
_____ Lab Reports
_____ History & Physical
_____ Operative Reports
_____ Other _____

SPECIFIC AUTHORIZATION

Substance Abuse Mental Health Treatment Information HIV (AIDS) Test Results

I acknowledge that data to be released MAY INCLUDE material that is protected by Federal Law to ANY or ALL of the above. My signature below authorizes release of all such information.

This office, its employees, and attending physicians are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

SIGNATURES:

Patient/Legal Guardian:_____ Date:_____

If not patient, relationship to patient:_____ Date:_____

Witness:_____ Date:_____