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AUTHORIZATION FOR RELEASE AND DISCLOSURE OF MEDICAL RECORDS FROM BETHANY WOMEN'S HEALTHCARE

I understand that my records are protected under state and federal laws and cannot be disclosed without my written consent except in specific instances described by law. The undersigned hereby authorizes the release of medical information as follows:

Patient Name:_____

Date of Birth: _____

Address: _____

Phone Number: _____

I authorize Bethany Women's Healthcare to release copies of information regarding my medical care and treatment to:

Name of Person or Facility: _____

Address or Fax Number:_____

_____

City, State, Zip: _____

Release the following information: _____

_____

Dated from:_____to _____

Purpose of release:_____

I understand that the information disclosed may contain matter that is protected by Federal and State laws, including information which may relate to alcohol, drug and psychiatric treatment, AIDS and/or HIV testing, and/or other sexually transmitted infections. I specifically consent to the release and disclosure of this information. I understand that transmitting records by facsimile may breach the confidentiality of my records. I release Bethany Women's Healthcare of all responsibility for any missed transmission and/or potential breach of confidentiality. If any records are more than 25 pages, I will be asked to pick them up or they will be mailed to the above-named person or facility.

I understand Bethany Women's Healthcare can only release medical records from care provided at this practice.

I understand my medical records will be released within 48 to 72 hours after this release has been signed by a provider.

_____ _____

Patient Signature **Date**

Provider's Signature:_____**Date:**_____