PARKWEST WOMEN'S HEALTH
1820 S. Clinton Ave. Rochester, NY 14618
FAX: 585-473-3098

Authorization for Release of Records

This form authorizes **PARKWEST WOMEN'S HEALTH** to disclose your records for the purpose described below. You should carefully read the information on this form before signing.

I, _____,Date of Birth: ____/____/____ authorize the following:

☐ Send my ParkWest Women's Health records to:
If there are more than 20 pages transmitted, there may be an administrative fee of $15.00.
Name: _____
Address: _____
_____
_____
Fax: _____ Phone: _____

☐ Get my previous records from:
Name: _____
Address: _____
_____
_____
Fax: _____ Phone: _____

1. ***I understand that if I've had one or more pregnancies at ParkWest Women's Health:***
   a. ***That my records WILL have references to HIV/AIDS testing.***
   b. ***ParkWest Women's Health may only release HIV/AIDS testing information with my permission.***

I GIVE my consent to release HIV/AIDS testing information _____
(initial)
I DO NOT GIVE my consent to release HIV/AIDS information_____
(initial)

2. ***I understand that if I have not had a pregnancy with ParkWest Women's Health, my record may still contain reference(s) to HIV/AIDS testing.***

I GIVE my consent to release HIV/AIDS testing information _____
(initial)
I DO NOT GIVE my consent to release HIV/AIDS information_____
(initial)

3. ***I understand that if my health record contains references to Alcohol/Drug Treatment ParkWest Women's Health may only release this with my permission***

I GIVE my consent to release Alcohol/Drug Treatment information _____
(initial)
I DO NOT GIVE my consent to release Alcohol/Drug Treatment information_____
(initial)

4. ***I understand that if my health record contains references to Mental Health Information/Psychotherapy Notes, ParkWest Women's Health may only release this with my permission upon completion of a separate authorization form: (provided upon request)***

☐ParkWest Women's Health will release the minimum necessary information from your records to fulfill your request. Please be specific in letting us know what information you want released.

☐Send only the following dates: **_____ to _____**

☐Send only the following selected items: _____

_____

Please indicate a reason for disclosure:

☐I want to update my other doctor
☐I am transferring care to ParkWest Women's Health
☐I am leaving ParkWest Women's Health and transferring my care to the above physician/facility.

Reason for leaving: _____

Expiration Date/Event. This authorization is valid until _____/_____/_____.
If not specified, this authorization is valid until **one year** from the date it was signed.

I understand that I have the right to revoke this authorization at any time, in writing, by mailing such written notification to the Privacy Officer, at the above address. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

I hereby authorize the use or disclosure of my health information as described in this form.

_____ _____
Signature of Patient or Personal Representative Date

_____
Print Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority