



PARKWEST WOMEN'S HEALTH
300 Red Creek Drive, Ste 100, Rochester, NY 14623
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 testing 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 testing 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