Northwest Women's Clinic
Obstetrics & Gynecology

FAMILY ACCESS TO MEDICAL RECORDS

1. Patient's Name: _____ Date: _____
2. Date of Birth: _____ Social Security Number:_____

PERMISSION IS HEREBY GRANTED FOR RELEASE OF INFORMATION

I HERBY AUTHORIZE Name: _____

DOB:_____

Relationship to patient:_____

TO HAVE FULL ACCESS TO MY MEDICAL RECORDS.

3. The following information may be released:
   _____ All Records _____ Medical Summary _____ Lab Data
   _____ Prenatal Labs/Records _____ Op Reports/Dates _____ X-Ray/Ultrasound Reports
   _____ Other _____

4. **SIGNATURE:_____ DATE:_____**

8. **Duration:** Release expires one year from date signed.
9. **Revocation:** I understand that I may revoke this authorization in writing at anytime.
10. **Re-disclosure:** I understand that the information disclosed to *Northwest Women's Clinic* may be subject to re-disclosure and no longer be protected under federal law. However I understand that federal law may restrict disclosure of drug/alcohol diagnosis, treatment or referral information, mental health information and genetic testing information.
11. **Conditions:** *Northwest Women's Clinic* may not base your treatment, payment, enrollment or eligibility for benefits on your providing protected health information from your previous health care provider.

I recognize that the information disclosed may contain Mental Health, Drug, or Alcohol information protected by federal and state law. I specifically consent to release of such information.

_____ _____
(Signature) (Date)

I recognize that the information disclosed may contain information regarding Sexually Transmitted Disease, HIV/AIDS Tests, or Genetic Testing Information. I specifically consent to disclosure of such information.

_____ _____
(Signature) (Date)

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