SWOR WOMEN'S CARE
Gynecology • Obstetrics • Infertility • Urogynecology

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PATIENT:

_____ _____
Name of Patient/ Previous Names Date of Birth

_____ _____
Street Address City, State, Zip Code

AUTHORIZES: **RELEASE OF PROTECTED HEALTH RECORDS TO**:

_____ _____
Name of Health Care Provider Name of Health Care Provider/Plan/ Other

_____ _____
Street Address Street Address

_____ _____
City, State, Zip Code City, State, Zip Code

INFORMATION TO BE RELEASED:

___ Full Medical Records as held by this office.
___Medical Records for the period_____ through _____
___ Specific Information, as requested below:
_____
_____

PURPOSE FOR NEED OF DISCLOSURE:

___Further Medical Care ___Insurance/Eligibility
___Other(specify)_____

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

I understand I must be provided with a signed copy of this authorization. I understand written notification is necessary to cancel this authorization and I may obtain information on how to withdraw my authorization by contacting the office of the above noted healthcare provider. I understand that Swor Women's Care will not be able to release my records to someone else without a signed authorization. If I decided not to sign this form, Swor Women's Care will not refuse to continue treatment. By signing this authorization, I do expressly and voluntarily consent to the disclosure of the information checked above to the person/doctor/agency named above. I understand that if the person and/or organization listed above are not mandated by the federal privacy standards, the health information disclosed because of this authorization may be redisclosed without obtaining my authorization. I understand that I may be charged a fee for copying these medical records.

Signature Patient/ Legal Rep: _____ Date: _____

AS NOTED IN THE HIPAA REGULATIONS:
"Section 164.506 of the HIPAA privacy regulations permit release of information for treatment, payment, or healthcare operation purposes without a specific patient authorization. Consequently, the regulation allows a mammography facility to transfer medical records to another covered entity in most situations without specific patient authorization. The Office of the Civil Rights, the KHHS office with primary responsibility for HIPAA implementation, has also stated that, a covered healthcare provider may share protected health information with another health care provider for the treatment purposes without a business associate contract."
Effective Date: 9/28/2021