Authorization for Disclosure of Health Information

I, the undersigned, authorize **Women's Health Alliance** to release my health information as noted below:

pka **CAPITAL AREA OB/GYN**
4414 Lake Boone Tr. #308
Raleigh, NC 27607
Phone: 919-781-7450

Patient Information

*********All sections must be completed in order for request to be processed*********

Patient Full Name: ______________________________ Other Names During Treatment? ____________________________

Patient Address: ____ Date of Birth: ______________________________

City:____________________ State:_______ Zip:______________ Phone #: ________________________________

Release Information To

Name/Facility: ____ Attention: ________________________________

Address: ____ Phone: ____________________________________

City: ____________________ State _______ Zip: ________________ Fax: ____________________________________

Purpose of Request: ☐ Personal ☐ Treatment ☐ Legal ☐ Insurance ☐ Disability
☐ Transfer/Reason________________________ ☐ Other_______________________________

Charges outlined below will be applied for all copies released directly to patient . The charge does not apply when the records are sent directly to a healthcare provider for ongoing treatment purposes.

Information to be Released

Please specify the Information to be released:

☐ Send all of my Records
☐ Send only my Records from:
(Date) ___/___/_____ to (Date) ___/___/_____
☐ Send only the following specified Records:
____

This Purpose of Releasing the Information:

☐ Continuity of Care
☐ Personal ☐ Second Opinion
☐ Complete Transfer of Care:
Reason: ___________________________________
☐ Other: ___________________________________

____
Initial Here

I understand I will receive an invoice from BACTES Imaging per Virginia Statutes and payment is made directly to BACTES Imaging. Questions about your request or invoice can be answered by calling:

All Fees are based on HIPAA guidelines
(North Carolina General Statute §90-411 applies)

- ***$0.75 per Page*** for up to 25 Pages.
- ***$0.50 per Page*** for Pages 26 – 100.
- ***$0.25 per Page*** for Pages over 100
- ***Minimum fee of $10.00*** permitted.

Authorization to Release Protected

*__Required__ - Please complete the check boxes below indicating how protected information should be handled even if the categories do not necessarily apply to the patient's medical records.

Check one — *Initial each line below*

I ☐ **DO** ☐ **DO NOT** want information about ***Mental Health** released ________

I ☐ **DO** ☐ **DO NOT** want information about ***HIV Tests** & **Related Information** released ________

I ☐ **DO** ☐ **DO NOT** want information about ***Alcohol and/or Substance Abuse** released ________

I ☐ **DO** ☐ **DO NOT** want information about ______________________________ released ________
"Other sensitive information?"

Please confirm that you have put a __checkmark and initialed all__ the protected information categories above regardless if they are applicable or not. If form is incomplete, or if protected information is not released, we may be unable to fulfill this request.

Patient's Signature____**Date:**________________
(Required for all patients 18 years and older. 18 years and older for psychiatric records, 14 years and older for substance use records)

Signature of Parent or Legal Guardian ____________________________**Date:** ________________
(Required for all patients under the age of 18 unless otherwise allowed by law. If not the parent, legal representation documentation must be supplied)

This authorization will expire 1 year from the date appearing above. I understand that I may revoke this authorization at any time by notifying the Health Information Management Department in writing, but if I do, it will not have any effect on the actions the clinic took before it received the revocation.

I understand that under the applicable law the information used or described pursuant to this authorization may be subject to redisclosure by the recipient and no longer subject to the protections of the privacy standard.

*I understand that my treatment or continued treatment by **Women's Health Alliance** and its affiliates in no way conditioned on whether or not I sign the authorization and that I may refuse to sign it.*

I understand that I may inspect or copy the information that is used or disclosed.

Rev. 10/1/11