Revision Date: 01/07/2025

CAPITAL WOMEN'S CARE
Working Together for Women's Health

AUTHORIZATION TO RELEASE PATIENT MEDICAL INFORMATION TO CAPITAL WOMEN'S CARE

I hereby authorize _____ to use and disclose my individually identifiable Protected Health Information (PHI) to Capital Women's Care in the manner described below.

I understand that I have the **right to access**[1] my complete medical records maintained by Capital Women's Care, based on the federal HIPAA law. I understand that when I want my records to be sent to Capital Women's Care, I will be asked to sign this form unless I have provided Capital Women's Care with a similar HIPAA-compliant form. I also understand that my Protected Health Information (PHI) may be re-disclosed by Capital Women's Care per my request, and that it then may no longer be protected by federal privacy regulations. The applicable state law may or may not prohibit such re-disclosure by the person or entity receiving my PHI from Capital Women's Care. I understand that signing this authorization is voluntary and will not condition my treatment, payment, enrollment or eligibility for benefits.

TYPE OF INFORMATION TO BE RELEASED/COPIED/PROVIDED TO CAPITAL WOMEN'S CARE:

1. **GENERAL RELEASE: I would like copies of the following types of Medical Record to be sent**:

____ Medical Records, excluding information the patient does not have a "**Right to Access**"
Please Check ONE:
All Dates: _____ **OR** From: _____ To: _____

___ A Continuity of Care Document (A summary listing which may include active allergies and adverse reactions, current medications, active problems, dates of services, immunizations, social history, last filed vital signs, lab results if applicable)

____ Lab Results, Pathology Reports, Radiology Reports (Please specify) _____

____ X-ray Reports (Please specify) _____

____ Operative Reports (Please specify) _____

____ Other Records, Progress/Physician Notes, History and physical Notes (Please specify) _____

____ Records related to genetic testing and results (Please specify) _____

TYPE OF INFORMATION NOT TO BE RELEASED/COPIED/PROVIDED TO CAPITAL WOMEN'S CARE:

2. **CONFIDENTIAL INFORMATION[2] PROTECTED BY STATE/FEDERAL LAW: I would like the following information excluded from the information released:**

____Drug or Alcoholism Abuse Diagnosis/Treatment (specify) _____

____ Psychiatric and/or psychological records or evaluation and/or treatment for mental health, physical and/or emotional illness including any narrative summaries, test, social work assessment, medications, psychiatric examination, progress notes, consultations and/or treatment plans. (specify) _____

____Sexually Transmitted Disease or AIDS/HIV Diagnosis/Treatment/Counseling (specify) _____

[1]An individual does not have a right to access PHI that is not part of a designated record set because the information is not used to make decisions about individuals. This may include certain quality assessment or improvement records, patient safety activity records, or business planning, development, and management records that are used for business decisions. In addition, two categories of information are expressly excluded from the right of access: Psychotherapy notes, and information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding. See 45 CFR 164.524(a)(1)(ii).

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PATIENT AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I certify that I have read, signed, and received a copy of this authorization upon my request or at the request of a representative legally authorized to make this request on my behalf. I understand that I may be billed for copies of my medical records from the entity sending them to Capital Women's Care according to applicable state and federal laws and guidelines. I understand that I have the right to receive a copy of this authorization. I also understand this authorization is valid for ninety (90) days only and may be revoked in writing at any time prior by notifying the entity releasing information in writing. I understand I have the right to revoke the authorization at any time except to the extent that action has been taken in reliance thereon.

PATIENT INFORMATION

Patient Name (Print): _____

Former Name (if applicable): _____

Social Security Number: _____

Telephone Number (Main): _____

Birth Date: _____

Email Address: _____

Home Address: _____

INFORMATION OF ENTITY SENDING REQUEST TO CWC

Name (Print): _____

Address: _____

Telephone Number (Main): _____

Fax Number (Main): _____

_____ _____

Signature of Patient/Legal Representative **Relationship to Patient, if not signed by Patient**

_____

Date

CWC Internal Use Only
Please Attach Invoice When Fulfilling the Request

Total Fee Billed: _____
Date Request was Received: _____
Date Request was Fulfilled (via email, fax, regular mail, or in-person pickup): _____