Aurora Womancare, PC

Authorization/Release for Protected Health Information (PHI)

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA) you have the right to request a copy of your health information. Your records will be copied within 30 days from date of request.

_____ Print Patient's Name

_____ Date of Birth

_____ Street Address

_____ Social Security Number

_____ City, State, Zip

_____ Daytime Phone Number

Reason for request: _____

If transferring care, why? _____

Type of Records: **Date(s) Requested**_____

___Entire Record (Last Five Years)

___Other (please specify) _____

___Labs

____I do ____I do not authorize the release of information related to HIV/AIDS, Psychological or psychiatric conditions, and treatment for alcohol and/or drug abuse.

Release to: _____ **Release by:** _____

_____ _____

_____ _____

This authorization will expire in 120 days from date of signature. I hereby authorize the facility listed below to disclose/release the Protected Health Information specified in this request to the organization, agency or patient named.

Signed: _____ Date_____

Revised 3/10/16