



Women Gynecology & Childbirth Associates, P.C.

1815 South Clinton Avenue – Suite 610
Rochester, New York 14618

1630 Empire Blvd
Webster, New York 14580

103 Canal Landing Blvd – Suite 11
Rochester, New York 14626

585-244-3430

CONSENT FOR RELEASE OF MEDICAL INFORMATION

I, _____, date of birth _____,

do hereby consent and authorize Women Gynecology & Childbirth Associates, P.C. to **send** my medical

records to _____ located at _____,

fax number ____ (____) _____ - _____.

A description of the Protected Health Information (PHI) to be released:

I consent to the disclosure of **all medical records** in the possession of the provider including records, reports or tests concerning alcoholism and/or drug abuse or treatment information, sexually transmitted disease related and/or psychological or psychiatric treatment, symptoms or treatment of AIDS including test results for presence of HIV or an antibody to HIV. I understand that this serves as a dual release. (This excludes any records transferred to WGCA from previous care providers).

I consent to the disclosure of **all medical records** with the following exceptions. *If you want to limit any records previously mentioned in any way, include exactly what you do not want released:* _____

I consent only to the release/obtainment of the following items: _____

Purpose of release: _____

To better serve our patients, we would appreciate knowing why you are transferring from our practice (if appropriate): NOT TRANSFERRING Moving Change in insurance Other (please specify) _____

NOTICE TO PATIENT: You may cancel this authorization in writing at any time, except where the release of PHI has already occurred. **This authorization will expire one year from the date of consent. For permanent records transfer, there is a fee of \$.75 per page for copying and administrative cost. This fee will not exceed \$20.**

Patient or Guardian Signature - *If there is a personal representative, a description of the representative's authority is required.*

Date

Witness

Date

Patient's Current Address _____ Phone ____ (____) _____
Street City State Zip

NOTICE TO RECIPIENT OF RECORDS: This information has been disclosed to you from records protected by Federal confidentiality rules. The Federal rules prohibit you from making any further disclosure of this information unless further disclosures are expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by State or Federal law.