WOMEN GYNECOLOGY & CHILDBIRTH ASSOCIATES, P.C.

777 Canal View Blvd., Suite 400, Rochester, NY 14623 P: (585) 244-3430 I F: (585) 244-2202

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 occured. **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.