GYNCARE

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient's name: _____ Date of Birth: _____ MRN _____

Address: _____ Phone _____
Street City State Zip

The undersigned hereby authorizes **Gyncare, Inc.**

Address: 235 Plain Street, Suite 307, Providence RI 02905 **Phone:** 401-223-2920 **Fax:** 401-223-2927

- ❑ To release/disclose the protected health information specified in this form to the following individual and/or entity
- ❑ To request/receive the protected health information specified in this form from the following individual/or entity

Recipient or Disclosing Party: _____ Phone _____

Address: _____ Fax _____
Street City State Zip

Please check one or more types of Health Information to be released/requested:

_____ Allergies	_____ Laboratory Results	_____ Operative Report
_____ Immunization Records	_____ X-Ray/Imaging Results	_____ Psychiatric Exam
_____ Emergency Dept. Records	_____ History & Physical	_____ Psychological Tests
_____ Registration Record	_____ Progress Notes	_____ Treatment Plan(s)
_____ Discharge Summary	_____ Consultation Reports	_____ Entire Record

Other (Please Specify) _____

The frame for which the Health Information should be released/Requested is for the period:
From _____ (Date) To _____ (Date) OR All Dates of Treatment _____ (Please initial)

The undersigned acknowledges, agrees and understands that unless specifically limited below, any Health information released may include mental health treatment information, alcohol and substance abuse treatment information, STDs and/or HIV/AIDS-related information.

DO NOT RELEASE The following Health Information (Please specify) _____

The undersigned acknowledges and understands each of the following:

- Authorizing the release of the Patient's Health information is voluntary
- Refusal to sign this authorization does not affect the patient's treatment, claims payment or health plan enrollment
- This authorization may be revoked at any time upon written request to the Provider's privacy officer except to the extent that release of Patient's Health Information has already occurred in reliance on this authorization
- This authorization automatically expires six (6) months from the date of the signature below
- Any information already released to the recipient may be re-disclosed and may no longer be protected

The undersigned has read and understands this authorization, has had any questions with respect to this authorization explained to his/her satisfaction and is authorized as the patient or the patient's legal representative to release the patient's Health Information.

_____ _____
Signature of patient or his/her legal Representative Date

_____ _____
Print name of patient or his/her legal Representative Relationship to Patient