For Women, Inc.

Authorization to Release Protected Health Information

Patient Name	Date of Birth	Phone Number
Patient Address		

1. I authorize the following health care facility/physician/hospital (referred to as "Health Care Provider"). to use and/or disclose my/the patient patient's individually identifiable health information as described in section 3 below.

Physician/Office Name	Phone	Fax
Physician/Office Address		

2. I authorize the following person(s) or organization(s) to ***receive*** the information:

   FOR WOMEN, INC 10475 Reading Rd. Suite 307 Cincinnati, OH 45241

3. **Type of Information to be Released**: check the type of information that you want to be used or disclosed pursuant of this authorization –

   a. **Medical Records**: ***CHECK ONE***

   ☐ All medical records; or

   ☐ I only want the part of my medical record described below to be disclosed:

   _____

   _____

   b. Billing Records:

   ☐ All billing records including itemized statement

   c. Dates of Treatment: ***CHECK ONE***

   ☐ All dates of treatment; or

   ☐ I only want records for the following dates of treatment to be disclosed:

   _____

   _____

- I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Medical Records Clerk of For Women, Inc...
- I understand that a revocation is not effective to the extent that For Women, Inc. has relied on the use or disclosure of the protected health information or the prior release of the protected health information as directed by this prior authorization.
- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- I understand that I have the right to receive a signed copy of this authorization.
- I understand that For Women, Inc. will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

Signature of Patient	Printed Name of Patient	Date