RHETT WOMEN'S CENTER

Authorization for Release of Protected Health Information

Pursuant to 45 C.F.R. & 164.508 of the regulation s promulgated under the Health Insurance Portability and Accountability Act ("HIPPA"), I hereby authorize the disclosure of my protected health information as described below. This authorization is provided to you voluntarily and that once released, the information may no longer be protected by HIPPA. This authorization shall expire one year from the below date. I am aware that I may revoke this authorization at any time by notifying you in writing, except to the extent you have taken actions in reliance on this authorization.

Patient Name: _____ Date of Birth: ____/____/_____

Persons/Organizations **providing** the information (provide complete address):

_____
_____
_____

Persons/Organizations **receiving** the information (provide complete address):

_____
_____
_____

Specific description of information, including relevant date(s): Any information and/or documentation in your possession, or under your control, relating to the medical care, examinations, treatment, x-rays, MRI's, CT's, hospitalization, or office records relating to the above referenced patient or other information as stated here: _____
_____

_____ _____
Patient Signature ***Date***

For Office Use Only: _____ _____
Date Records Released Initial

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