

**Comprehensive Women's Health Service, PLLC**

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Watertown, New York 13601

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*Authorization for Release  
Of Medical Information from  
CWHS*

Patient Name	Birth Date	Social Security Number	Medical Record Number
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Address	Phone Number
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I hereby authorize Comprehensive Women's Health Services to release personal health information from the medical records of the above named patient:

To: \_\_\_\_\_  
Name and Address of Person/Organization to which disclosure is to be made

For the following purpose: \_\_\_\_\_

For the following dates of service (must be completed) \_\_\_\_\_

Type of Access Requested	Select Portions requested		
<input type="checkbox"/> Copies of Record	<input type="checkbox"/> View Record Only	<input type="checkbox"/> Labs	<input type="checkbox"/> MD Progress Notes
<input type="checkbox"/> Entire record	<input type="checkbox"/> Imaging/Radiology	<input type="checkbox"/> MD Orders	<input type="checkbox"/> Consultations
<input type="checkbox"/> Other _____	<input type="checkbox"/> History and Physical	<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Pathology report
	<input type="checkbox"/> Operative/Procedure	<input type="checkbox"/> Other _____	
	<input checked="" type="checkbox"/> HIV		

**This authorization expires \_\_\_\_\_ or unless specified, 90 days from the date signed below and covers only treatments for the dates specified.**

I, the undersigned, have read the above and authorize Comprehensive Women's Health care Services to disclose such information as identified above on this form. I understand that this authorization may be withdrawn by me at any time by notifying Comprehensive Women's Health Services in writing at any time except when the information has already been released by Comprehensive Women's Health Services through this authorization. This practice is released and discharged from any liability and the undersigned will hold the practice harmless, for complying with this form, "Authorization for Release of medical information".

_____ Date	_____ Signature of Patient/Parent/Guardian/Healthcare Proxy	_____ Relationship/Authority
	_____ Print Name	

**All fees/charges will comply with all laws and regulations applicable to release of information. Although information should not be re-disclosed, it may be dispersed by another entity during routine treatment, payment, or operations and therefore, would not be covered by Federal regulations. Federal Register, department of health and Human Services, 45 CFR, Standards for privacy of Individually Identifiable Health Information, Section 164.524.**