

# Carolina Women's Research & Wellness Center Women's Wellness Clinic

## Authorization for Release of Information Form

I hereby authorize use or disclosure of protected health information about me as described below.

PATIENT NAME \_\_\_\_\_ DOB \_\_\_\_\_ MRN \_\_\_\_\_  
(Medical Record Number)

The following specific person(s) or facility is authorized to make the requested use or disclosure:

RECORDS MAILED/FAXED FROM:	RECORDS MAILED/FAXED TO:
Andrea Lukes, MD   Scarlet Dial, FNP Mary Hixon, NP 249 East Highway 54, Suite 330 Durham, NC 27713 Phone: 919-251-9223 Fax: 919-251-9343	    

### Information to be released:

- Medical Records       Lab reports       Radiology reports (MRI, CT, PET, X-rays, etc)  
 Hospital/ER Records       Prescriptions       Other: \_\_\_\_\_

### Specific description of information to be released:

- All Dates       Specific date(s): From \_\_\_\_\_ to \_\_\_\_\_

### The information to be released will be used for the purpose described below:

- Continuing health care       Clinical Research

Other: \_\_\_\_\_

- I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.
- I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclose of this type of information. Please initial if you consent or do not consent to the release of this information.        **YES, I consent.**           **NO, I do not consent.**
- I may revoke or withdraw this authorization by notifying **Women's Wellness Clinic** in writing of my desire to revoke it. However, I understand that any action already taken in advance of this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.
- This authorization will expire on \_\_\_\_\_, or 1 (one) year after the date of said authorization.

**THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING.**

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

(If patient is a minor/has Power of Attorney)