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 ANP 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)