Women's Birth & Wellness Center
930 Martin Luther King Jr. Blvd., Suite 202
Chapel Hill, NC 27514
Tel: 919-933-3301 Fax: 919-933-3375

AUTHORIZATION FOR REQUEST OF MEDICAL RECORD INFORMATION
This authorization expires ninety (90) days from date of signing

Patient name: _____ DOB: _____

I hereby authorize:

Name of person or facility:_____

Address: _____

Phone number: (_____)_____ Fax number: (_____)_____

To disclose my protected health information to Women's Birth & Wellness Center.

The specific information to be disclosed is: _____

_____

_____

Beginning and ending dates: from _____ through _____

The purpose of this disclosure is: _____

- I understand that my protected health information may be re-disclosed by the Women's Birth & Wellness Center, and would at that time no longer be protected by federal privacy regulations.
- I understand that I may revoke this authorization at any time by notifying Women's Birth & Wellness Center in writing of my desire to revoke authorization. However, I understand that any action already taken on reliance of this authorization can not be reversed, and my revocation will not affect those actions.
- I understand that Women's Birth & Wellness Center may not condition treatment of me upon whether or not I sign this authorization.
- I understand that this authorization will become a part of my medical record with Women's Birth & Wellness Center and that I have the right to a copy of this authorization at any time.

ATTN: Information about alcohol or substance abuse, HIV/AIDS, or mental health,

□ May be disclosed _____ □ May not be disclosed
(signature)

Signature of Patient/Guardian: _____ Date: _____

If signed by Guardian, relationship and description of authority to act for the patient: _____

_____