Exceptional Care
FOR WOMEN

Authorizations For Use or Disclosure of Medical Record Information

Medical Record #

6011 E. WOODMEN ROAD STE 305, COLORADO SPRINGS. CO 80923
PHONE: 719-884-9962 FAX: 719-884-9963

Patient Information:

Patient Full Name: _____ Date of Birth: _____

Patient Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____ Work Phone: _____

☐ I hereby authorize Exceptional Care for Women to release my medical records to the following:

☐ I hereby authorize the following to release my medical records to Exceptional Care for Women:

Name/Facility: _____ Attention: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____ Fax: _____

Purpose of Request: ☐ * Personal ☐ Continuing Care ☐ * Legal ☐ * Insurance ☐ * Other _____

*** COPY FEE:** We reserve the right to charge a reasonable fee for the cost of producing and mailing the copies. Base fee of $15 per chart. Please make checks payable to Exceptional Care for Women. Charts will be copied once payment is received.

Information to be released:

PLEASE BE SPECIFIC – Include dates of treatment & provider name if applicable.

_____ Date (s) of Treatment _____

_____ Date (s) of Treatment _____

Authorization for Release of Statutorily Protected Information:

DO NOT leave this section blank – The requested medical record MAY or MAY NOT contain information that is statutorily protected. You must check either "Yes" or "No" and initial each category for Exceptional Care for Women to properly process your medical record request.

	Release Record? Check one YES	or	NO	
Mental Health	☐		☐	Initial Here: _____
HIV Tests & Related Information	☐		☐	Initial Here: _____
Alcohol and/or Substance Abuse	☐		☐	Initial Here: _____
Genetic or Hereditary cancer testing	☐		☐	Initial Here: _____

Please confirm that you have checked "Yes" or "No" and initialed all 3 protected information categories above even if they do not necessarily apply to the patient's records. If information is not released and/or form is incomplete, ECW may be unable to fulfill this request.

Sensitive Information:

Please check or indicate below any sensitive information that you **DO NOT** want released.

☐ Abortion ☐ Sexually Transmitted Disease ☐ AIDS/ARC

☐ Genetic ☐ Domestic Sexual Assault ☐ Other (s) _____

_____

Patient's Signature **Date***

_____

Parent/Legally Recognized Representative Signature/Relationship to Patient** **Date***

Know Your Privacy Right
Refer to the HIPAA
"PRIVACY POLICY"

_____

Witness **Date**

*This Authorization is valid for 90 days (30 days for alcohol/drug abuse treatment) unless you specify otherwise: _____. You may revoke this Authorization at any time by providing a written statement to ECW where the Authorization was originally submitted, except to the extent that ECW has already completed action on it.

Authorizations For Use or Disclosure of Medical Record Information

** By my signature, I attest that I am the legally responsible representative of the above mentioned patient in accordance with the following:

_____.

The information released pursuant to this Authorization may be re-disclosed by the receiving institution or individual or other individuals or organizations that are not subject to privacy protection laws. ECW will not condition treatment or payment of the provision of this Authorization. Patient does have the right to receive a copy of this form