THE WOMEN'S SPECIALISTS

Patient Authorization Form for Inspecting and Copying Health Information

Patient Name: ______________________________ **Medical Record #:** ________________

Date of Birth: ____________________ **SSN:** ________________________________

Phone Number: ________________________ ____________________________
(area code - home) (area code - work)

A. I desire access to and/or copies of medical information created and maintained by The Women's Specialists. I authorize The Women's Specialists and/or the Health Care facility named below to copy and disclose my health information.

B. The information to be disclosed is (specify the exact information to be disclosed) for

(dates of service): ______________________________

I request and authorize: Name: ____________________________________

Address: ____________________________________

City, State, Zip: ________________________________

__________ Entire Medical Records

__________ Lab __________ X-Ray __________ EKG __________ Stress Test

__________ Immunization Records __________ Progress Notes

__________ Other: ____

I understand that this information may include information relating to: acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV infection); treatment for drug or alcohol abuse; or mental or behavioral health or psychiatric care, excluding psychotherapy notes.

C. Purpose of disclosure: ____________________________

D. The information should be sent to the following: Kenneth West, MD - The Women's Specialist
(Name & Address)
1002 Texas Blvd, Ste 200 Texarkana, TX 75501
(903)792-1404 Fax (903)792-2681

I understand that to the extent any Recipient of this information, as identified above, is not a "covered entity" under Federal or Texas privacy law, the information may no longer be protected by Federal and Texas privacy law once it is disclosed to the Recipient and, therefore, may be subject to re-disclosure by the Recipient.

I understand that The Women's Specialists may not condition treatment on my completion of this authorization form.

E. Unless otherwise revoked, this authorization will expire 90 days from the date on this request;

I may revoke this authorization form at any time. Initials: ________

I understand that The Women's Specialists may charge a fee for the costs of copying, mailing, or other supplies associated with this request.

____ ______________________________
Signature of patient or patient''s representative Date (month/day/year)

Printed name of patient's representative: ________________________________

Relationship to patient giving representative authority to act for patient: ______________________