Suburban Women's HEALTHCARE, PC

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OBSTETRICS & GYNECOLOGY

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

PATIENT NAME:_____ **DATE OF BIRTH:**_____

1. I authorize Suburban Women's Healthcare, PC to release my protected health information to: _____
2. I authorize Suburban Women's Healthcare, PC to obtain my protected health information from: _____
3. RELEASE OF HIV/AIDS/SEXUALLY TRANSMITTED RELATED-DISEASES, PSYCHOLOGICAL, PSYCHIATRIC, DRUG OR ALCOHOL ABUSE TREATMENT INFORMATION.

   _____ YES PLEASE SEND _____ NO DO NOT SEND

4. The type of information to be disclosed is as follows: (Please Check)

   _____ Most recent history and physical, pap smear, mammogram
   _____ Blood work
   _____ Operative reports
   _____ Prenatal notes
   _____ Medication list (Gardasil, Depo-Provera flow sheets)
   _____ Imaging reports (mammograms, Dexa scans or ultrasounds)
   _____ Entire record

5. _____ I AM NOT TRANSFERRING MY CARE FROM SUBURBAN WOMEN'S HEALTHCARE, PC
   _____ I AM LEAVING SUBURBAN WOMEN'S HEALTHCARE, PC. THE REASON IS:
   _____
6. $0.75 PER PAGE FEE. I UNDERSTAND THAT I AM RESPONSIBLE FOR THE COPYING FEE AS ALLOWED BY NEW YORK STATE PUBLIC HEALTH LAW 18.
7. THIS AUTHORIZATION EXPIRES 1 YEAR FROM THE DATE LISTED BELOW.
8. I UNDERSTAND THAT AUTHORIZING THE DISCLOSURE OF THIS HEALTH INFORMATION IS VOLUNTARY. I CAN REFUSE TO SIGN THIS AUTHORIZATION. I UNDERSTAND I MAY INSPECT OR COPY THE INFORMATION TO BE USED OR DISCLOSED AS PROVIDED IN CFR 164.524. IF I HAVE QUESTIONS ABOUT THE DISCLOSURE OF MY HEALTH INFORMATION, I CAN CONTACT THE STATE MEDICAL RECORDS LAW OFFICES AT (913)385-7990.

SIGNATURE _____ **DATE**_____

WITNESS _____ **DATE**_____