



Authorization For Use And Disclosure Of Protected Health Information
Inbound

10131 Forest Hill Blvd, Suite 130 • Wellington, FL 33414 • ph: (561) 784-1933 • fax: (561) 784-5109 • TheWHI.com

Form with fields: Patient Name, Date of Birth, Verification of Identity (Driver's License, ID Card, Passport, etc.), Social Security Number

Complete the following only if the person authorizing the use or disclosure is not the patient:

Form with fields: Name, Relationship to Patient, Legal Authority, Verification of Identity (Driver's License, ID Card, Passport, etc.), Verification of Authority

By signing this form, I authorize:

Form with fields: Name, Address, Phone, City, State, Zip, Fax

To mail or fax my copies of my medical record(s) to:

The Women's Health Institute

10131 Forest Hill Blvd, Suite 130

Wellington, FL 33414

phone: (561) 784-1933 • fax: (561) 784-5109

Reason:

- Reason options: Transferring care to a new Ob/Gyn, Coordinating care with another physician, Second opinion, Other

The specific information I wish to have released is:

- Consent terms: I understand that I may revoke this consent at any time, except where information has already been released. This authorization is valid for sixty (60) days from the date it is signed. This medical record may contain information about drug abuse, alcoholism, alcohol abuse, venereal disease, abortion, or mental health treatment. Separate consent must be given before this information can be released. This medical record may contain information concerning HIV testing and/or AIDS diagnosis or treatment. Separate consent must be given to have this information disclosed

Patient / Legal Representative Signature

Date

Witness Signature

Witness Name

Date