Authorization For Use And Disclosure Of Protected Health Information
Outbound

The Women's Health Institute™ 10131 Forest Hill Blvd, Suite 130 • Wellington, FL 33414 • ph: (561) 784-1933 • fax: (561) 784-5109 • TheWHI.com

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:

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:

The Women's Health Institute
10131 Forest Hill Blvd, Suite 130
Wellington, FL 33414
phone: (561) 784-1933 • fax: (561) 784-5109

Reason:

- ☐ Transferring care to a new Ob/Gyn
- ☐ Coordinating care with another physician
- ☐ Second opinion
- ☐ Other_____

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

Name _____

Address _____ Phone _____

City _____ State _____ Zip _____ Fax _____

The specific information I wish to have released is: _____

_____

- 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