PREMIER WOMEN'S HEALTH, LLC

NAME DATE

AUTHORIZATION FOR RELEASE OF INFORMATION

I understand and authorize my medical information to be released to Premier Women's Health from:

_____

_____

This information is to be released to:

PREMIER WOMEN'S HEALTH
DR. CAROLYN KOLLAR
1758 BROAD PARK CIRCLE SOUTH
MANSFIELD, TEXAS 76063
FAX (972) 780-7385

I understand that the information is to be release for the following purposes (mark all that apply):

___TREATMENT ___REFERRAL ___CO-MANAGEMENT ___CONTINUITY OF CARE

___RECORD REVIEW ___PATIENT REQUEST ___OTHER: _____

Information to be requested from the following time period:

From: _____ (month/year) To: _____ (month/year)

I hereby authorize Premier Women's Health to use/disclose my protected health information in accordance with the current Health Insurance Portability and Accountability Act (HIPAA) guidelines. I understand that I may be responsible for any processing fee that may be required for the requested information. Identification will be required for patient privacy and confidentiality. I understand that my medical information may include sensitive health information. I understand that I may revoke this authorization in writing at any time. I understand that this authorization expires 180 days from that date of my signature. A photocopy of this authorization is considered as valid as the original. I understand that if the recipient authorized to receive that health information is not a health plan or healthcare provider the released information may no longer be protected by federal and state privacy regulations.

_____

Signature of Patient or Legal Representative Date

_____

If Representative, specify relationship to patient Date

*** * * If more than 10 pages, please mail the records to our office. * * ***