# AUTHORIZATION TO RELEASE PROTECTED HEALTHCARE INFORMATION (PHI)

ALLIANCE WOMEN'S HEALTHCARE
DR. JONATHAN SNEAD, FACOG

Patient Name :_____
Prior Name/Names: _____
Date of Birth:_____ SSN: _____

**Providers:** Send Records to Dr. Jonathan Snead, Alliance Women's Healthcare
10932 North Riverside Drive, Suite 100, Fort Worth, TX 76244
(P) 817.741.9663 (F) 817.741.3691

**REQUEST RECORDS**: *(CIRCLE ONE)* *FROM* *TO*

PHYSICIAN: _____

ADDRESS : _____

_____

PHONE:_____ FAX:_____

**This request and authorization applies to (choose one):**.

**IMPORTANT:** Unless otherwise stated, this paragraph applies to all options below if the described type of testing includes the following information: I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person or entity listed above. I understand that the person listed above will be notified that I must give specific permission before disclosure of these tests results to anyone. I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person or entity listed above. **Specific conditions/treatment:** *Definition:* Sexually Transmitted Disease (STD) results as defined by law. RCW 70.24 et. Seq. includes herpes, herpes simplex, human papilloma virus (HPV), wart, genital wart, Condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL immunodeficiency syndrome, and gonorrhea.

☐ All healthcare information as follows: office notes, ultrasounds, labs, flowsheet AND:

_____ Phone messages
_____ Patient Ledger (billing)
_____ Demographics – driver's license, insurance card
_____ Privacy paperwork signed by the patient
_____ FMLA paperwork
_____ Letters
_____ Mammograms
_____ Pathology reports
_____ Operative reports

What date range are you looking for? _____

**NOTE: We may not send documentation that has been provided to us which was sent by another Provider such as medical records or office notes or scans which were performed by another Provider.**

**Reason for records:**_____

**THIS AUTHORIZATION EXPIRES 180 DAYS AFTER SUBMISSION:** I understand that if my PHI is disclosed to someone who is not required to comply with the federal privacy protection regulations then such information may be re-disclosed by that person or entity and would no longer be protected. I also have the right to inspect a copy of my own PHI to be used or disclosed (in accordance with the requirements of the federal regulations found under 45 C.F.R. 164.524).

*I have read and understand this consent and I have signed it voluntarily and of my own free will.*

Patient Signature: _____ Date:_____