ALLIANCE WOMEN'S HEALTHCARE – AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

1. I hearby authorize JONATHAN C SNEAD MD PA d/b/a ALLIANCE WOMEN'S HEALTHCARE ("AWH"), located at 10600 N. Riverside Drive, Suite 100, Fort Worth, Texas 76244, Phone (817) 741-9663, Fax (817) 741-3691, to release the following information for:

Patient's Name: _____ Maiden: _____

Patient's Date of Birth: _____ Phone: _____

By: ☐ Fax: _____ ☐ Pick Up (by whom) _____

☐ Other: _____

2. Information is to be released to:

Physician/Facility: _____

Address: _____

Phone: _____ Fax: _____

3. Information to be released (**pick one (a) entire record or (b) portion of a record below**):

(a) ☐ **My entire record from the dates of _____to _____:** I understand that checking the box for "my entire record" authorizes the use or disclosure of all information in my medical record including, but not limited to: demographic information, patient histories, medication lists, tests, and diagnoses. It may NOT include records provided by other physicians unless our office ordered the report (such as a mammo or an ultrasound). If you want phone calls included, check here: ☐ .

(b) ☐ A **portion of my record**, including what I check below, for the dates of _____ to _____:

☐ Visit Notes ☐ Labs: _____

☐ Mammogram ☐ Ultrasound/Radiology ☐ Operative/Procedure Notes ☐ Genetic Test: _____

☐ Other: _____

4. Purpose of this disclosure is for Continuity of Care, Treatment, Payment, or Healthcare Operations. If that is not the case, the purpose of this disclosure is for: _____.

5. I understand this consent can be revoked in writing at any time except to the extent that AWH has relied on this Authorization. Unless otherwise revoked, I understand that the date or event upon which this Authorization expires is 180 days from the date of the signature. Written revocation should be addressed to: 10600 N. Riverside Drive, Suite 100, Fort Worth, Texas 76244.

6. A photostatic copy of this Authorization is to be construed as valid as the original.

7. By my signature at the end of this Request, I specifically authorize the use or disclosure of any information in my medical record related to the history, diagnosis, and the treatment of drug or alcohol abuse, mental illness, behavioral health, psychiatric care, communicable diseases, including HIV and AIDS, Genetic information, Genetic history or counseling, Genetic testing and results, and/or other sensitive information.

8. I understand to the extent that any recipient of this information, as identified above, is not a "covered entity" under Federal or Texas privacy laws, the information may no longer be protected by Federal and Texas privacy law once it is disclosed to the recipient, therefore, may be subject to re-disclosure by the recipient. I understand my information disclosed pursuant to this Authorization could be re-disclosed by the recipient subject to Chapter 159 of the Texas Occupations Code and the Health Insurance Portability and Accountability Act.

_____ _____

Signature of Patient/Legal Representative Printed Name/Relationship of Legal Representative

_____

Today's Date

For OFFICE USE only: Request received on: _____