

**Outside Record Release or Disclosure of Health Information**

 Please Print Clearly

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Last 4 digits of SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| Records to be Released From  |
|  Name: |
| Address: |
| Telephone: |
| Fax: |

**Records to be Released to: Women’s Wellness of Southern Delaware, LLC**

 **17015 Old Orchard Road**

 **Unit 2**

 **Lewes, Delaware 19958**

 **Phone: (302) 257-5372 Fax: (302) 203-6939**

**Please send the information below:**

\_\_\_Entire Chart

 OR

\_\_\_Last office note

\_\_\_Last Mammogram, Bone Density, PAP

\_\_\_Vaccine List

\_\_\_Prenatal Records

Reason for Request: TRANSFER OF CARE

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| I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment. I give my authorization for these records to be released unless specifically excluded. My initials below indicate records EXCLUDED from this authorization. The following protected information is NOT authorized for release:\_\_\_\_\_\_\_ Drug/Alcohol abuse/treatment and diagnosis \_\_\_\_\_\_\_\_Sexually Transmitted Disease\_\_\_\_\_\_\_ HIV/AIDS diagnosis/treatment/testing \_\_\_\_\_\_\_ Mental Illness or Psychiatric diagnosis |

I understand I do not have to sign this authorization in order to obtain healthcare benefits (treatment, payment or enrollment) and that I may revoke this authorization in writing at any time except to the extent action has been taken in reliance on this authorization. I understand that the information authorized for disclosure (except drug and alcohol treatment records) may be subject to re-disclosure by the recipient listed above, at which time it my no longer be protected under federal HIPPA Privacy Rules.

**Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**