Arcadia Well Woman

Dale Ann Dorsey, MSN WHNP-BC, Mary Frazee, MSN WHNP RDMS, Elia Valdivia, WHNP

Authorization for Release of Information

Patient Name: _____ Date of Birth: _____

SSN: _____

I authorize Arcadia Well Woman to release my medical and/or billing information to the following individual(s):

1. _____ Relation to Patient: _____
2. _____ Relation to Patient: _____
3. _____ Relation to Patient: _____

Contact Information for the Individual(s) (Listed Above)

1. _____ Phone Number: _____
2. _____ Phone Number: _____
3. _____ Phone Number: _____

☐ Please release **ALL** my medical records to the individual(s) listed above. Note: We consider medical records received from other providers to be part of our records.

☐ Please release my **Most Recent** medical records, including but not limited to, pathology, laboratory test results, diagnostic test, and radiology.

☐ Please release my most recent ☐ Pap ☐ Labs ☐ Radiology ☐ Pathology

☐ Please release information received from other healthcare providers.

• Information related to the following will not be disclosed unless **initialed** below:
___ Drug/alcohol treatment ___ HIV-related info ___ Mental health info

Patient information:

I understand I have the right to revoke this authorization, in writing, at any time. I understand that the information disclosed to any above recipient is no longer protected by federal or state law and may be subject to redisclosure by the above recipient.

Signature of Patient: _____ Date: _____