Advanced Menstrual Care Center
Control your period. Improve your life!

Authorization for Release of Health Information

Revocation (if requested)
Date Revoked:_____

Patient Name: _____ **Birthdate:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____ **Phone:** _____

Email: _____ **MR#:** _____

I authorize Advanced Menstrual Care Center LLC to take the following action(s):

REASON FOR REQUEST (CHECK ✓ONE):

☐ At request of the patient ☐ For my care/treatment ☐ For legal reasons ☐ For payment/insurance reasons

ACTION REQUESTED (CHECK ✓ ONE):

☐ Provide a copy of identified health information to patient. ☐ I wish to review my health information. I do not want a copy.

☐ Release patient's identified health information to: ☐ Discuss patient's identified health information with:

☐ Obtain patient's identified health information from:

For Office Use Only

_____
Name of person or entity

_____
Address

_____ **Fax:** _____
City State Zip

INFORMATION REQUESTED (CHECK ✓ ALL THAT APPLY): ☐ Billing Record(s) ☐ Substance Abuse _____ Initial

☐ Abstract (Discharge Summary, Admission History & Physical, Operative Report(s), Pathology Report(s), Diagnostic Testing) ☐ Operative Report ☐ Pathology Report ☐ Admission History & Physical ☐ Discharge Summary

☐ Diagnostic Testing (Lab Reports, X-Rays, CT Scans, MRI, Ultrasounds, etc.) ☐ Immunization Record(s)

☐ Progress Note(s) ☐ Mental Health Record(s) ☐ Infectious Record(s), (_____ Initial Include _____ Initial Exclude HIV/AIDS)

☐ Radiology/Procedure Images ☐ All Records ☐ Pap Smear Results

RECORDS REQUESTED FOR PERIOD: FROM:_____ TO _____.

Signature:_____ **Date:**_____

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Patient Name: _____Birth Date: _____

I understand and agree that I am responsible for the security and confidentiality of all Personal Health Information which is transferred to my possession. I take responsibility for securing this information in a manner consistent with recommended practices, including but not limited to, encryption, physical access and security control, secure transmission techniques etc. I further understand that standard email, texting, cellular transmission and internet transmission are not secure. Additional risks including misdirection, misaddressing, message forwarding, shared email, hacking methods including phishing, transfer to portable devices, etc. I acknowledge and accept these risks and others, known and unknown.

I further understand that:

- **This authorization is voluntary. My treatment will not be affected whether I sign this authorization or not.**
- **This authorization is valid for one year from date signed unless I revoke this authorization or unless an earlier date is specified here: _____.**
- **I may revoke this authorization at any time, except to the extent that action has been taken prior to receipt of the revocation. I must submit my request to revoke this authorization in writing to Advanced Menstrual Care Center LLC.**
- **Once my health information is disclosed as requested, it may be subject to redisclosure by the person(s) receiving it and may no longer be protected by federal and state privacy laws.**
- **The medical information released may contain information related to HIV status, AIDS, sexually transmitted infections, mental health, drug and alcohol abuse, genetic disorders, etc.**
- **Advanced Menstrual Care Center LLC will not condition the provision of treatment or payment on the provision of this authorization.**

FORMAT REQUESTED:

☐ On paper in person ☐ On paper via mail ☐ By encrypted email

Patient Signature: _____ Date: _____