ID #: ___________________

WEST COAST
WOMEN'S SPECIALISTS

HIPAA RELEASE OF MEDICAL INFORMATION

I hereby authorize Westcoast Women's Specialists to use and disclose my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that my health care provider cannot guarantee that the recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this authorization or applicable federal and state law governing the use and disclosure of my health information. I hereby release all parties from any/all legal liability that may arise from the release of this information to the party named above.

PATIENT NAME: ____

DOB: ________________________________

NAMED PARTY:________________________________ RELATIONSHIP:____________________________________

Do not list other Healthcare providers. This is only for friends, family, or other personal relationships.

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AUTHORIZATION: (Choose all that apply)

- ☐ Billing information
- ☐ Limited to: (Choose all that apply)
  - o Birth Control
  - o STD testing
  - o Pregnancy
  - o All of my medical related information (billing included)
  - o Other ____
- ☐ I decline to disclose my information

I understand that this authorization will expire 1 year from the date signed unless otherwise revoked. I understand that I may revoke this authorization at any time by notifying Westcoast Women's Specialists in writing; however, if I do revoke the authorization, it will not have any effect on any actions taken by Premier OB/GYN, LLC prior to their receipt of the revocation.

__________________________________ Patient Signature

__________________________________ Witness Signature

__________________________________ Date

__________________________________ Date