Women's Health & Wellness
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AUTHORIZATION FOR RELEASE OF INFORMATION

Name of Patient _____

Birth date_____ Social Security Number_____

Name of Parent/LegalGuardian_____

I authorize Jeanette M. Pilotte, MD to:

_____ Release To _____Receive From

Dr's Office/Individual_____
Address_____City_____State/Zip_____
Phone Number_____ Fax Number_____

_____Consultation/Progress Notes
_____Testing/Lab Results
_____Other:_____

I understand that these records may contain information pertaining to chemical dependency issues and or HIV communicable disease testing and or treatment.

Information may be written, verbal or both. Jeanette M. Pilotte, MD FACOG, is hereby released from any and all liability that may arise from the disclosure of the information requested. I certify that this request for disclosure has been made freely and voluntarily. I understand that I may revoke this authorization at any time. IN WRITING, except to the extent that the action has already been taken on the consent. Unless otherwise specified this consent expires 1 year from the date of signing.

Note: A photocopy and/or fax of this consent shall be considered valid as the original.

Signature_____ Date_____

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This information has been disclosed to you from records protected by federal confidentiality rules (42CFR Part 2). The Federal rules prohibit you from making any further disclosure is expressly permitted by the written consent to whom it pertains or as otherwise permitted by 42CFR Part 2. A general authorization for release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.