AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

Patient Name: _____

Date of Birth: _____ Social Security No.:_____

Address: _____

_____ Phone No.:_____

I authorize: Physician Name: _____
Office Address: _____
_____
Phone No.:_____ Fax No.:_____

To Disclose Information to: Morris Wortman, M.D., FACOG
The Center for Menstrual Disorders and Reproductive Choice
2020 South Clinton Avenue, Rochester, NY 14618
Phone: 585-473-8770 Fax: 585-473-8853

Information to be disclosed (please circle all that apply):

ALL records Physician notes Labs Surgical Notes

Pathology (including PAP) Mammograms OTHER: _____

Dates of service: _____

Purpose of disclosure: (purpose may be listed as "at the request of the patient") _____

_____

Limitations regarding this Authorization: _____

I authorize Dr. Wortman to disclose information from medical records, films, test results and other information regarding hospitalization, follow-up treatment and physical rehabilitation of the above named patient for the period specified. This Authorization includes general confidential medical information. I understand that the information used or disclosed pursuant to the Authorization may be re-disclosed by the recipient, and that the information may no longer be protected by the practice or by the HIPAA Privacy Rules.

This Authorization is subject to revocation at any time, except to the extent that the provider, who is to make that disclosure, has already taken action in reliance on it. If not previously revoked, this Authorization will terminate as of (specific date, event or condition) _____

I understand that this Authorization is voluntary, that I do not have to sign this Authorization in order to receive treatment from the practice, and that I can change my mind and revoke this Authorization at any time by providing a revocation in writing to the Privacy Officer. I understand that the practice will provide me with a copy of this Authorization.

I understand that the practice will not receive payment or other remuneration from a third party in exchange for using or disclosing the information other than a record copying and/or processing fee. For permanent records transfer, there is a fee of $ .75 per page for processing and administrative costs.

_____ _____

Signature of Patient (or person authorized by law) **Witness Signature**

Date Signed: _____