Women's Specialty Care, LLC

Optimizing Pregnancy Outcomes

PLEASE SEND RECORDS TO:
WOMEN'S SPECIALTY CARE, LLC
970 N. KALAHEO AVE
STE A-108
KAILUA, HI 96797
PHONE - 808-762-1996 **FAX - 808-441-0022**

Medical Records REQUEST - ***Limited Patient Authorization for Disclosure of Protected Health Information***

Patient Name: _____ **Date of Birth:** _____

I authorize _____ **(the entity or individual identified below) to disclose or provide Women's Specialty Care, LLC (Fax: 808-441-0022) my protected health information to . I understand that in the event the facility is unable to accommodate an electronic delivery as indicated, an alternate delivery will be provided. I understand there is a level of risk associated with receiving unencrypted electronic media or email and the provider is not responsible for unauthorized access to the protected health information contained in this type of format. I also understand the facility is not responsible for any risks (e.g., virus) potentially introduced to any computer / device.**

Release FROM (Please print):

Name: _____

Address: _____

City, State & Zip: _____

Phone Number: _____

Fax Number: _____

Email Address: _____

Preferred Delivery Method:

- ☐ **Mail – Paper Copy**
- ☐ **Pick Up – Paper**
- ☐ **Facsimile (855 348-9504)**
- ☐ **Unencrypted Email**

Information to be disclosed (Check all that apply)

Dates of treatment:

☐	**Chart Notes / Visit Summary**	☐	**Outside Consult Notes**
☐	**Laboratory Results**	☐	**Other:**
☐	**Ultrasound Report**	☐	
☐	**Ultrasound Images**	☐	
☐	**Outside Imaging**	☐	
☐	**Entire Medical Record**	☐	

Purpose of disclosure – Please list the purpose of the disclosure or check patient request.

☐ **Patient Request** ☐ **Other (please specify) :** _____

Inclusions – I understand the disclosure of individually identifiable health information may include information concerning communicable diseases such as HIV or AIDS testing and/or results, mental illness information (excluding psychotherapy notes), and drug/alcohol/substance abuse information.

Expirations or termination of authorization – I understand this authorization will expire one year from the date of your signature below, unless I specify an earlier termination. A photocopy of this authorization will be treated in the same manner as the original and that I will get a copy after it is signed. I must submit a new authorization after the expiration date to continue the authorization. I have the right to terminate this authorization at any time. I must notify the privacy manager, in writing, if I decide to terminate the authorization prior to the normal expiration date.

(Please list an earlier expiration if less than one year): _____

Right to revoke or terminate – As stated in the Notice of Privacy Practices, I have the right to revoke or terminate this authorization, except to the extent that the provider has taken an action in reliance to the authorization prior to your termination.

Redisclosure – The provider has no control over the person(s) I have listed to receive my protected health information. Therefore, my protected health information disclosed under this authorization will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of Women's Specialty Care.

Non Conditioning – There is no restriction of my treatment as a condition for signing this authorization.

Right to Copy – I understand that I may see and obtain a copy of the information described on this form if I request it.

Marketing – I understand this request for protected health information is not for marketing purposes and, in no way, involves the sale of my protected health information. The recipient will not further exchange the information for financial remuneration.

Patient or Guardian Signature: _____ **Date:** _____

Relationship to Patient: _____

Internal Use - Released By : **Date:** _____ **Time:** _____ **Acct #:** _____