Modern Women's Care

AUTHORIZATION FORM TO RELEASE MEDICAL INFORMATION

Patient Name _____

Date of Birth _____

I, _____ hereby authorize Modern Women's Care to use and disclose Protected Health Information (PHI) to:

Name of Provider or Organization _____

Address _____

Phone number _____

Information to be disclosed, check all that apply:

☐ Medical Records (chart notes) ☐ Diagnostic Records (Ultrasound, labs) ☐ Other _____

This protected health information is being used or disclosed for the following purposes:

- ☐ Share medical information with other healthcare providers
- ☐ Personal use
- ☐ Transferring care to a new healthcare provider
- ☐ Legal investigation
- ☐ Other: _____

_____ _____

Signature of Patient/Patient's representative Date

_____

Printed name of person signing above

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