Women's Healthcare Center of Williamsburg

CONSENT TO RELEASE HEALTH INFORMATION

Patient Name _____ Other Name(s) Used _____

Address _____ Date of Birth _____

_____ Social Security # _____

Phone # _____

I hereby authorize: **Women's Healthcare Center of Williamsburg**
6050 Village Drive
Lincoln, NE 68516-4732
(402) 421-8581 office **(402) 421-8594** fax

To Release Medical Information to: _____ (name of agency/person)

_____ (address)

_____ (phone #) _____ (fax #)

Describe Information to be Released: _____

For the Purpose Of: _____

Date: _____ Signature: _____ Witness: _____

___ Individual
___ Parent (if individual is under the age of 19)
___ Legal Guardian

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY FEDERAL LAW

I specifically authroize the release of data and information relating to: (circle appropriate response)

1. Substance abuse (alcohol/drug abuse)	Yes	No	Does Not Apply
2. Mental Health	Yes	No	Does Not Apply
3, HIV Related Information (AIDS related testing)	Yes	No	Does Not Apply

Date: _____ Signature: _____

I understand that you have no responsiblity for the use of distribution of this information by the party to whom it is released. I release yo from all liability, which my arise from your compliance with this request is to release records. I authorize you to transmit this information by facimile transmission (fax), and release you from any liability for breach of confidentiality, misdirection of transmission or failure to receive transmission if my records are transmitted by facimile (fax).