



Authorization for Release of Health Information to Third Party

I request that health information regarding my care and treatment be released as set forth on this form and in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

I understand that:

1. I hereby authorize the release of my information by Bloom Women's Clinic in a secure manner.
2. I have the right to revoke this authorization at any time in writing to Bloom Women's Clinic. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
3. I understand that signing this authorization is voluntary and for my benefit. This authorization is not a condition to any treatment, payment, enrollment, or eligibility of benefits.
4. I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or Human Immunodeficiency Virus (HIV), alcohol and drug use. I authorize the release or disclosure of this type of information.
5. Name and address of agencies to which you are authorized to release information:

OR

- Prenatal care provider is yet to be determined. I will contact the center with this information.

6. Specific information to be released:

Medical Record/Ultrasound Report from ___/___/___ to ___/___/___

Other (please specify): _____

7. This authorization will expire in ninety (90) days unless otherwise noted: _____

By signing below, I am stating that all items on this form have been completed and my questions about this form have been answered. I understand that I can request a copy of this form.

Patient's Name: _____ Date of Birth: _____

Patient's Signature: _____ Date: _____