

SOUTHEAST WOMEN'S CENTER

William Turlington, MD
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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Name: _____ DOB: _____ Phone #: _____

PLEASE OBTAIN INFORMATION FROM:

PLEASE SEND INFORMATION TO:

Name of Provider/Clinic

Name of Provider/Clinic

Street or PO Box Address

Street or PO Box Address

City, State, Zip Code

City, State, Zip Code

Phone: _____ Fax: _____

Phone: _____ Fax: _____

I AUTHORIZE the following information to be disclosed: (Please initial that apply)

____ Entire Record

____ HIV Record

____ Billing Records

____ Immunization Record

____ STD Record

____ Other _____

____ Lab Test

____ Psychiatric/Mental Health

____ Date(s) _____

____ TB Test

____ Alcohol/Substance Abuse

REASON for disclosure of health information: (Please initial)

____ At my request

____ Job

____ Other _____

____ Continuing Care

____ School

____ Legal

____ Insurance

EXPIRATION of this Authorization: (Please initial one)

____ 90 days after signature date ____ On this date: _____

____ When this event happens: _____

ADDITIONAL PATIENT INFORMATION:

- I understand that I have the right to withdraw this authorization. To withdraw, please sign below.
- I understand that I do not have to sign this authorization to get treatment.
- I understand that once my health care information is disclosed as I have authorized, it could be re-disclosed by the recipient and is no longer protected by Southeast Women's Center.
- I understand that signing this authorization does not cancel any rights I have under the other state or federal laws.

Client Signature (Parent or Legal Representative) Relationship Date: _____

Witness Signature: _____

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