

# HARMONY WOMEN'S HEALTHCARE

**ALL PATIENTS PROVIDE THE FOLLOWING INFORMATION:**

May we release appointment, billing and medical information and/or test results to anyone other than you?    YES    NO

Name of Person we may release your information to: \_\_\_\_\_

- I hereby authorize Harmony Women's Healthcare to release periodic status reports from the medical records of the patient listed below. The reports may be released to other physicians or facilities participating in my care.
- I understand my records are confidential and cannot be disclosed without my written authorization, except otherwise provided by law.
- I understand that records pertaining to the diagnosis and/or treatment of HIV/AIDS testing, psychiatric illness and alcohol or chemical abuse dependency will not be released unless I have given my specific consent to release this information.
- I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance upon it and that this authorization will automatically expire on one year from the date signed.
- I understand that a photocopy or facsimile of this authorization is a valid as the original.
- I authorize the release of any medical billing or other information necessary to process claims on my behalf.
- I agree to be fully responsible for all lawful debts incurred by myself for services received from Harmony Women's Healthcare.

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**Signature of Patient**

**Date**

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**Print Name**