WESTSHORE PRIMARY CARE

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

HIPAA Compliant Request for Information

Name of Patient (Please Print) | Date of Birth (00/00/0000) | SSN

Address | City | State | Zip Code

I hereby give the following entity permission to release my Protected Health Information (PHI):

Full name of entity | Address | City | State | Zip Code

I instruct the above named entity to produce the following information:

- □ Complete Health Record
- □ History and Physical Exam
- □ Progress Notes
- □ Discharge Summary
- □ Consultation Reports
- □ Laboratory Tests
- □ Emergency Dept Record
- □ Abstract/Pertinent Info
- □ Other _____
- □ Radiology Reports
- □ Specified Date(s) of Service Only_____

HIV, Behavioral Health, or Drug and Alcohol Abuse/Treatment information contained within the dates of service I have specified above ***are to be released through this authorization*** unless specified below:

DO NOT RELEASE: □ HIV □ Behavioral Health □ Drug/Alcohol

I authorize the above listed records to be released to:

Westshore Midwifery Associates
Colleen Brezine, CNM, Susan Dornan, CNM, Maureen Stein-Vavro, CNM,
Sharon Johnson, CNM and Colleen Zelonis, CNM
29101 Health Campus Drive, Building 2, Suite 250
Westlake, OH 44145
Phone: 440-827-5483 Fax: 440-827-5453

At my request, my PHI is to be disclosed for the following purpose: _____

This authorization expires: □ Ninety (90) days from signature □ One (1) year from signature □ One-time release

I may revoke this authorization at any time by mailing or personally delivering a signed, written notice of revocation to the healthcare provider at which this authorization was executed. Such revocation will be effective upon receipt, except to the extent that the recipient has already taken action in reliance on this Authorization. I am entitled to a copy of this authorization upon my request. I may not be required to sign this Authorization as a condition to obtaining treatment, payment or eligibility for benefits. The information that I am requesting to be disclosed may be re-disclosed by the recipient and may no longer be protected by law. I hereby acknowledge that I have read and fully understand the above statements as they apply to me.

Signature of Patient | Date

Signature of Parent/Guardian or Personal Representative (attach proper documentation) | Date

Copy: **Patient**
Medical Record of Patient