Women's Health Alliance, PA pka
Centre Ob/Gyn

Phone 919-788-4444
Fax 919-788-4464

Authorization for Disclosure of Health Information

I, the undersigned, authorize **Women's Health Alliance, PA pka Centre OB/GYN**
4414 Lake Boone Trail, Suite 205 Raleigh, NC 27607 to release my health information as noted below:
Please return the **COMPLETED** authorization to this address.

Patient Information

All sections must be completed in order for request to be processed

Patient Full Name: _____ Other Names During Treatment? _____

Patient Address: _____ Date of Birth: _____

City: _____ State _____ Zip: _____ Phone#: _____

Email Address: _____

Release Information To: (THIS SECTION MUST BE COMPLETED)

Name/Facility: _____ Attention: _____

Address: _____ Phone: _____

City: _____ State _____ Zip: _____ Fax: _____

Purpose of Request: ☐ Referral by WHA to Another Provider ☐ Second Opinion OR Transfer of Care to Another Physician

☐ Personal Records ☐ Other/Reason _____

Information to be Released

Please specify the information to be released:

☐ Office Notes ☐ Labs ☐ Operative Notes ☐ Diagnostic Reports

Specify Date(s) of Service: _____

☐ **Entire Chart**

***** PAYMENT OPTIONS: Check, Credit Card or Money Order**
Charges outlined below will be applied for all copies released directly to patient or sent on patient behalf.
***Invoice must be paid before records will be released.**

****North Carolina Statute §90-411:** $0.75 for first 25 pages, $0.50 for *pages 26 - 100, $0.25 for pages over 100,* ***Minimum fee of $10.00***.

STOP _____ ***Initial Here***

I understand BACTES Imaging will MAIL an invoice for records per North Carolina Statutes and payment is made directly to **BACTES Imaging. Questions about your request or invoice can be answered by calling: (877) 270-4365

Authorization to Release Protected Health Information

***Required** - Please complete the check boxes below indicating how protected information should be handled even if the categories do not necessarily apply to the patient's medical records.

Check one *Initial each line below*

☐ **I DO** ☐ **DO NOT** want information about ***Mental Health** released _____
☐ **I DO** ☐ **DO NOT** want information about ***HIV Tests** & **Related Information** released _____
☐ **I DO** ☐ **DO NOT** want information about ***Alcohol and/or Substance Abuse** released _____
☐ **I DO** ☐ **DO NOT** want information about _____ released _____

"Other sensitive information?"

STOP Please confirm that you have put a checkmark and initialed all the protected information categories above regardless if they are applicable or not. If form is incomplete we may be unable to fulfill this request.

Patient's Signature_____**Date:**_____
(Required for all patients 18 years and older.)

Signature of Parent or Legal Guardian_____**Date:** _____
(Required for all patients under the age of 18 unless otherwise allowed by law. If not the parent, legal representation documentation must be supplied)

- *This authorization will expire 1 year from the date appearing above. I understand that I may revoke this authorization at any time by notifying the Practice Privacy Officer in writing, but if I do, it will not have any effect on the actions the practice took before it received the revocation.*
- *I understand that under the applicable law the information used or described pursuant to this authorization may be subject to redisclosure by the recipient and no longer subject to the protections of the privacy standard.*
- *I understand that my treatment or continued treatment by **Women's Health Alliance, P.A.** is in no way conditioned on whether or not I sign the authorization and that I may refuse to sign it.*
- *I understand that I may inspect or copy the information that is used or disclosed.*

Rev. 2/15