THE Women's Clinic AT THE GROVE

5740 Getwell Road
Building 1, Suite B
Southaven, MS 38672

Phone 662.470.7969
Fax 844.830.7467
info@wcgrove.com

Authorization for Release of Records TO The Women's Clinic At The Grove, LLC

Name _____ **DOB** _____ **Date** _____

I, _____ , do hereby authorize the following facilities _____

_____

_____

to release to **The Women's Clinic At The Grove, LLC** the medical records prepared by personnel of the clinic, hospitals, staff physicians/providers or other health care providers between the dates of _____ and _____ relating to my care in said facility for the purpose of continuity of care.

The information released shall include the following types of treatment:

☐ **Entire Medical Record**

☐ Radiology Reports ☐ Lab Results ☐ Operative Reports

☐ Other _____

_____

I **DO NOT** want the following information released: _____

Expiration Date:

- This will expire **six (6) months** after the date recorded below.
- This authorization covers only treatment prior to the date recorded below.
- I understand I may revoke this authorization at any time with a written request to the Health Information Management Department of the facility listed above. The request to revoke authorization must contain the signature of the patient.
- Revocation of this authorization is allowable only to the extent that the release of the information has not already occurred and/or only if facility has not taken action in reliance thereon.
- I understand that treatment, payment, enrollment or eligibility for benefits may not be conditioned on obtaining this authorization.
- I further understand that any disclosure of records concerning diagnosis and/or treatment for alcohol or drug abuse is covered by Title 42 of the Code of Federal Regulations, and if there is any such information, I hereby authorize the release of the information.
- This authorization also includes any information related to diagnosis and/or treatment of any genetic condition, psychiatric or mental illness and/or any state of infection with the HIV (AIDS) virus.
- This authorization covers materials considered "hospital records" reasonably capable of being reduced to printed form.

The Women's Clinic at the Grove and its affiliates are hereby released from all legal liability that may arise from the release of the information requested. Please note that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected under the applicable federal law.

Signature _____ Date _____

Relationship of Signed by Other Than Patient _____ Social Security _____

Street Address _____

City _____ State _____ Zip _____

Phone _____

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Authorization for Release of Records FROM The Women's Clinic At The Grove, LLC

Name _____ **DOB** _____ **Date** _____

I, _____

do hereby authorize **The Women's Clinic At The Grove, LLC** to release to _____

_____

_____

the medical records prepared by personnel of the clinic, hospitals, staff physicians/providers or other health care providers between the dates of _____ and _____ relating to my care in said facility for the following purpose(s):

☐ Continuity of Care ☐ Personal Health Record ☐ Legal ☐ Other _____

The information released shall be limited to the following types of treatment:

☐ **Entire Medical Record**

☐ Other _____

_____

I **DO NOT** want the following information released:_____

_____

Expiration Date:

- This will expire **six (6) months** after the date recorded below.
- This authorization covers only treatment prior to the date recorded below.
- I understand I may revoke this authorization at any time with a written request to the Health Information Management Department of the facility listed above. The request to revoke authorization must contain the signature of the patient.
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