REQUEST FOR INFORMATION

ELITE WOMEN'S CARE CENTER, PA
18400 Katy Freeway, STE 400 Houston, TX 77094
Office 281 579 9900 / Fax 281 579 9914

By signing this form, I hereby provide authorization for release of my confidential health information to **Elite Women's Care Center, PA**. I consent to the release of my medical records, including information regarding HIV/AIDS, Mental Health, Alcohol and/or Drug Abuse to the aforementioned **Elite Women's Care Center, PA**. My authorization releases the provider of this information from any liability for complying with this authorization.

_____ _____

Patient / Guardian Authorization Signature Date of Authorization

PLEASE COMPLETE REQUESTED INFORMATION IN ITS ENTIRETY

SPECIAL INFORMATION REQUESTED: SPECIFY TIME PERIOD REQUESTED (Please Check One)

Physician Name:_____

Physician Adress:_____

Phone#_____ **Fax#**_____

DATE OF SERVICE: FROM ___ _____ TO _____

___HISTORY & PHYSICAL ___PATHOLOGY ___IMAGING

___PROGRESS NOTES ___OPERATIVE REPORTS ___ALL RECORDS

___LABORATORY RESULTS ___PRENATAL RECORDS

Patient Name: _____ DOB:_____

Address:_____

City, State, ZIP:_____

Elite Women's CARE CENTER
18400 Katy Freeway Suite 400, Houston, TX 77094
Phone: 281 579 9900 Fax: 281 579 9914

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize *Elite Women's Care Center* to release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION WILL EXPIRE 1 year UNLESS REVOKED IN WRITING.