WOMANKIND
OBSTETRICS and GYNECOLOGY

Main Office: 725 Buckles Ct. North, Suite 230
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Release of Medical Records

Dear: _____

_____

_____

I, _____ D.O.B. _____ SS# _____ Hereby authorize and request you release my records to:

_____

_____

_____

To examine or receive a copy of any and all records, reports and charts, including x-rays, pertaining to my diagnosis, psychiatric care or treatment, HIV/ AIDS - related conditions, treatment of drug/alcohol abuse, and/or surgery.

The above information is release for the following purpose and that purpose only. Any other use is forbidden.

☐ Insurance or other third-party reimbursement
☐ Other physician or medical facility
☐ Pending legal action
☐ Personal review
☐ Other (*please specify*) _____

I understand that I may inspect or copy the information used or disclosed under this authorization.

I understand that if the person or entity who receives my protected health information is not covered by the federal health care privacy regulations, the personal health information disclosed may be re-disclosed to another person or entity and it will no longer be protected by the federal healthcare rules.

I understand that Stephen R. Richards, M.D., Inc. d/b/a WomanKind Obstetrics and Gynecology may receive compensation for the use or disclosure of my protected health information.

I understand that I may refuse to sign this authorization and that this refusal will not affect my ability to obtain healthcare treatment from Stephen R. Richards, M.D., Inc. d/b/a WomanKind Obstetrics and Gynecology, payment for this treatment, or my ability to enroll in a healthcare plan or be eligible for healthcare plan benefits.

I understand that I have the right to revoke this authorization at any time, in writing, by notifying Stephen R. Richards, M.D., Inc. d/b/a WomanKind Obstetrics and Gynecology's privacy officer, except to the extent that Stephen R. Richards, M.D., Inc. d/b/a Obstetrics and Gynecology has relied upon this authorization.

_____ _____ _____

Date Signature of Patient or Legal Representative Consent Expiration Date

(Consent will expire 1 year from signature date unless specified otherwise.)