1107 S Lemay Ave, Suite 300 •Fort Collins, Colorado •80524
Telephone directly 970/495-7973 • Fax 970/495-7992
www.fcwc.com

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT NAME:____ FORMER NAME: _____________________

BIRTHDATE:____ SOCIAL SECURITY NO.:_______________

PHONE:____

THIS AUTHORIZATION APPLIES TO THE FOLLOWING INFORMATION:

Mammogram films and reports only

PURPOSE OF REQUEST:

□ Treatment or consultation for care.

□ Transfer of care

□ Other: ________________________________
____

□ I wish for this to be a permanent transfer to WCNC

□ I wish for my films to be returned to the previous facility

I understand that these records may contain information regarding the diagnosis or treatment of HIV (AIDS virus), other sexually transmitted diseases, drug and/or alcohol abuse or treatment, mental illness, psychiatric treatment or Hepatitis B or C testing. I give my specific authorization for these records to be released.

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer at The Women's of Northern Colorado, 1107 S. Lemay Ave., Suite 300, Fort Collins, CO 80524. Unless revoked, this authorization will expire 90 days from the date of signature. I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Reliability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form unless specified above under Purpose of Request. I can view or receive a copy of the protected health information to be used or disclosed. **I authorize The Women's Clinic of Northern Colorado to use and/or disclose the protected health information specified above.**

_______ REQUEST FOR MEDICAL INFORMATION
(records from another facility to send to WCNC)

From Facility: ________________________________

Address: ________________________________

City/State: ________________________________

Phone: ________________________________

Fax: ________________________________

_______ AUTHORIZATION TO RELEASE
(for WCNC to send to another facility)

Send To: ________________________________

Address: ________________________________

City/State: ________________________________

Phone: ________________________________

____ ____________________
SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE DATE SIGNED

____
WITNESS

Revised 6/2009