SOUTHEAST WOMEN'S CENTER

William Turlington, MD
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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Name: _____ DOB:_____ Phone #:_____

PLEASE OBTAIN INFORMATION FROM:	PLEASE SEND INFORMATION TO:
_____	_____
Name of Provider/Clinic	Name of Provider/Clinic
_____	_____
Street or PO Box Address	Street or PO Box Address
_____	_____
City, State, Zip Code	City, State, Zip Code
Phone: _____ Fax :_____	Phone:_____ Fax: _____

I AUTHORIZE the following information to be disclosed: (Please initial that apply)

_____Entire Record _____HIV Record _____Billing Records
_____Immunization Record _____STD Record _____Other_____
_____Lab Test _____Psychiatric/Mental Health _____ Date(s)_____
_____TB Test _____Alcohol/Substance Abuse

REASON for disclosure of health information: (Please initial)

_____At my request _____Job _____Other_____
_____Continuing Care _____ School _____
_____Legal _____Insurance _____Leaving the Practice

EXPIRATION of this Authorization: (Please initial one)

_____90 days after signature date _____On this date:_____
_____When this event happens:_____

ADDITIONAL PATIENT INFORMATION:

I understand that I have the right to withdraw this authorization. To withdraw, please sign below.

I understand that I do not have to sign this authorization to get treatment.

I understand that once my health care information is disclosed as I have authorized, it could be re-disclosed by the recipient and is no longer protected by Southeast Women's Center.

I understand that signing this authorization does not cancel any rights I have under the other state or federal laws.

_____ Date: _____
Client Signature (Parent or Legal Representative) Relationship
Witness Signature: _____

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