The Women's HEALTH GROUP
www.whg-pc.com

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I authorize the use or disclosure of health information about me as described below.

The following individual or organization is authorized to disclose the information:

Name: _____

Address: _____

City, State, ZipCode: _____

Fax: _____

Phone:

The following individual or organization is authorized to receive the information:

- ☐ Stephen Volin, M.D.
- ☐ Vernon Naake, M.D.
- ☐ Cindy Long M.D.
- ☐ Kristin Head, M.D.
- ☐ Kristen Garcia, M.D.
- ☐ KimberLee Barnes, M.D.
- ☐ Courtney Amerin, D.O.
- ☐ Courtney Perez, CNM
- ☐ Angela Gilmer, CNM
- ☐ Aubre Tompkins, CNM
- ☐ Valorie Hauck-Sorensen, CNM
- ☐ Katie Danielson, CNM

of

The Women's Health Group, PLLC
9195 Grant Street, Suite 410
Thornton, CO 80229
Phone (303)280-2229
Fax (303)991-1721

The information will be disclosed for thes purpose(s)_____

The information to be disclosed:

- ☐ Specific condition(s)_____
- ☐ Tests/Lab results only _____
- ☐ All medical records generated by this provider
- ☐ Specific dates of treatment
- ☐ Other _____

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and substance abuse.

Re disclosure: I understand that any disclosure of information carries with it the potential for re disclosure and that the information then may not be protected by federal confidentiality rules.

Right to Revoke: I understand that I may revoke this authorization in writing at any time. I understand that the revocation will not apply to information already released based on this authorization.

Other Rights: I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.

Expiration: This authorization will expire on _____ (date, event, or condition).

_____ _____
Signature of Patient or Representative | Date

_____ _____
Patient Name | Date of Birth

_____ _____
Maiden/Other Names Used | SS#

_____ _____
Name of Personal Representative (if applicable) | Relationship to Patient