



Women's Clinic of Johnson County

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## AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Previous Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

**I request and authorize \_\_\_\_\_ to  
release healthcare information of the patient named above to:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**This request and authorization is for the date range:** \_\_\_\_\_ to \_\_\_\_\_ for

- Provider Office/Visit Note(s)     Ultrasound Report(s)     Immunization(s)  
 Lab/Pathology Report(s)     Operative/Procedure Report(s)     Other: \_\_\_\_\_

**The purpose for this request:**  Continuity of Care     Insurance     Self     Transfer of Care (Permanently Leaving)  
 Other: \_\_\_\_\_

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized re- disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

**I have read the information provided on this release form and fully understand the terms and conditions of this authorization.**

Patient Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

**THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED**