AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION SIGNATURE MEDICAL GRAOUP, INC.

Patient's Full Name (Print):	
Former Name(s) (where applicable):	
SSN:	Date of Birth:
Phone:	Fax:

I, or my personal representative, hereby authorize Signature Medical Group, Inc. (Signature or SMG) to use or disclose protected health information (PHI) regarding my care and treatment. I understand that:

1. PHI relating **ALCOHOL/DRUG ABUSE, MENTAL HEALTH GENETIC TESTING, HIV/AIDS** and/or communicable diseases may be included in records and I authorize disclosure of such PHI. As applicable, I specifically authorize release of certain treatment or conditions by placing my initials in the appropriate space(s) in 8 (b).

2. Information that is disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by federal or state law. If I am authorizing the disclosure of HIV/AIDS information, the recipient is prohibited for re-disclosing the information without my authorization, unless permitted to do so under state or federal law. I have a right to request a list of people who may receive or use my HIV/AIDS information without authorization.

3. I have the right to revoke the authorization at any time by providing a written notice of revocation to the provider at the address listed in Item 5 below, except to the Signature has already relied upon the authorization.

4. Signing this authorization is voluntary. SMG may not condition treatment, payment, enrollment in a health plan or eligibility for benefits on my signing or refusal to sign this authorization, except in limited circumstances.

5. Provider releasing this information (one Provider per form): Name:_____

Address:_____ Phone:_____ Fax:_____

6. Purpose for release of information: At my request Continuity of Care Other:_____

7. Person(s) to receive this information: Send to Name:_____Women's Health Partners_____.

Address: 10012 Kennerly Rd Suite 405 St. Louis, MO 63128 Phone: 314-525-4880 Fax: 314-525-4881.

I will pick up My personal representative_____ will pick it up (identification required for pick-up)

Note: Requests are subject to payment of copying/mailing fees and request may be processed by an SMG business associate

8. Description of information being release: (a) Date(s) of service (required; list all dates)**:** _____

I would like (choose one): An abstract (pertinent information related to the above listed date(s)) My entire Medical Record

X-ray/MRI/Other Radiology (specify) _____

Other (specify) _____

(b) Include information relating to (initial beside each applicable category**):** Alcohol/Drug Treatment_____

Mental Health Treatment_____ Genetic Testing Information_____

Psychotherapy Notes (complete a separate authorization form for these notes)_____ HIV/AIDS _____

9. Date or event on which this authorization will end: One-Time Request Specific Event or Date:_____

10. Signature: By signing below I acknowledge that I have read and agree with all of the above.

Signature: _____ Date: _____/_____/_____

Print name of personal representative if signing for patient and specify authority:_____

(supporting documentation required): Parent Guardian Health Care Agent Administrator/Executor Other_____

Note: When an authorization is sought by SMG, a signed copy of this form must be given to Patient or Personal Representative after signing.

If you do not want a copy, please sign here. _____