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PROGRESSIVE WOMENS HEALTH, PLLC
ASIA MOHSIN, MD

AUTHORIZATION FOR RELEASE OF INFORMATION

Last Name: _____ First Name: _____ Date of Birth: _____

I, undersigned, hereby consent to, and authorize Asia Mohsin, MD at Progressive Womens Health (PWH), PLLC the following

☐ to release to

and/or ☐ to release from

Clinic/Doctor's Name: _____
Telephone: _____ Fax: _____
Address: _____
for the period of _____ through _____ my confidential medical records, which may include protected health information (HIPPA), substance abuse information of HIV-related information.

The information to be release and/or received should include:

☐ Medical History and Information
☐ Immunization Records
☐ Substance Abuse/Mental History
☐ Billing Information
☐ Sexually Transmitted Diseases, Inc. HIV
☐ Imaging Reports
☐ Prenatal Records
☐ Laboratory Results/Reports
☐ Transfer/Termination or Discharge Summary
☐ **ALL OF THE ABOVE**

I acknowledge that I have the right to revoke this authorization in writing at any time by sending such written notification to the releasing person/agency. I understand that my revocation will not be effective to the extent that PWH has already taken action in reliance of this authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has the legal right to contest the claim. I further acknowledge that even if I revoke this authorization, the use and disclosure of my protected health information could possibly still be required as indicated in the copy of the Notice of Privacy Practices of Progressive Womens Health, PLLC that I have received and reviewed. I acknowledge that the re-disclosure of my protected health information may be accomplished by the authorized recipient(s) and that it will no longer by protected by Federal Privacy Rule. I acknowledge and understand that I am waiving my right to confidentiality with respect to the information or records released pursuant to this consent and I hereby release Progressive Womens Health, PLLC and its staff from any and all liability arising from the release and disclosure of the information or records. A photocopy or fax of this authorization is as valid as original.

I acknowledge that I have read this authorization for release of information in its entirety and I fully understand its terms and implications. I freely, voluntarily and without any coercion, agree with the terms and conditions contained in this authorization.

Patient/Guardian's Name: _____
Patient/Guardian's Signature: _____
Date: _____