Dahlia Woods, MD
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CONSENT TO RELEASE CONFIDENTIAL INFORMATION

1. I, _____ (print your name), am requesting the release of my protected health information.

2. I authorize Dahlia Woods, MD to disclose information regarding my treatment to the person or organization listed below. I authorize Dr. Woods to 1.) receive information from this party or parties and 2.) provide information to this party or parties.

3. I authorize Dahlia Woods, MD to disclose the above noted information to this person and/or organization:
   Name of Person or Organization: _____
   Phone Number: _____
   Fax Number: _____
   Full Mailing Address: _____
   _____
   Email Address: _____

4. The information will be used/disclosed for the following purposes (e.g. coordination of care, referral, etc.):
_____

5. I understand and agree that this authorization will be valid for one year from this date unless specified otherwise here: _____
I understand that after that date or event, no more of this information can be used or released to the person or organization unless I sign a new form.

6. I understand that I can revoke or cancel this authorization at any time through a written and signed request. If I do this, it will prevent any disclosures after the date it is received but cannot change the fact that some information may have been disclosed before that date.

7. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from the professional or facility listed at number 2, above, nor will it affect my eligibility for benefits.

8. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, that Dahlia Woods, MD cannot guarantee the ongoing privacy of the disclosed information.

9. I understand and agree that there may be administrative charges associated with the use or disclosure of my health information. The relevant financial arrangement has been explained to me and I understand and accept it.

10. I affirm that everything in this form that was not clear to me has been explained.

_____ _____
Signature of patient or his/her personal representative Date

I, Dahlia Woods, MD have discussed the issues above with the patient and/or the patient's personal representative. My observations give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ Dahlia Woods, MD _____
Signature of professional Printed name of professional Date