Natchitoches Women's Care

Martin Aviles, MD FACOG *Obstetrics and Gynecology*#
#

AUTHORIZATION TO DISCLOSE INFORMATION WAIVER OF CONFIDENTIALITY
To Send

All information that has been gathered on an individual is personal and private. You are not required to release this information. I understand that Natchitoches Women's Care will not condition treatment or payment on whether I sign this authorization unless I indicate that I am permanently transferring my care to another physician or facility. Such information cannot be released without authorized written permission, except as required by law as indicated in our privacy policy.

I understand that the information in the record of:

Patient Name: _____ Date of birth _____
Address: _____
City, State, Zip: _____

Is personal and private. **HOWEVER, I GIVE MY PERMISSION FOR:**

Name: Martin Aviles, M.D. Phone: 318-352-9595
Address: 627 Bienville Circle Fax: 318-352-9818
City, State, Zip: Natchitoches, LA. 71457-5744

TO RELEASE TO:

Name: _____ Phone: _____
Address: _____ Fax: _____
City, State, Zip: _____

THE FOLLOWING SPECIFIC INFORMATION:

_____

I understand that I have the right to refuse to disclose HIV test results.
☐ **I DO NOT AUTHORIZE** release of HIV test results.

The above listed information is to be released for the specific purposes of:

_____

I understand that my permission to release this information may be canceled at any time except when the information has already been released. My permission to release this information will expire: (____/____/____). I understand that the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.

The undersigned certifies that he/she is the parent/guardian/representative of the person listed above and has the legal authorization to sign on behalf of the person, whether by court order, or by operation of law.

Authorized Signature: _____Date: _____
Relationship to Patient: _____
Witness: _____Date: _____