Girls to Women HEALTH AND WELLNESS
16980 DALLAS PARKWAY, SUITE 204
DALLAS, TEXAS 75248
PHONE 972-733-6565 FAX 972-733-6564
Young Men's HEALTH AND WELLNESS

Susan Sugerman, MD, MPH **Mary Ann Franken, MD**
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Patient Name: _____ Date of Birth: _____/_____/_____

REFERRAL: ***It is your responsibility to let us know if this provider is in-network or out-of-network for your health insurance plan***. Your insurance may require your medical provider to complete additional forms ($25 fee) for an out-of-network provider referral. If you do need a referral with records sent to a provider, please notify our office by signing this form and mailing or faxing to us.

____ Provider is **IN-Network** with my current insurance

____ Provider is **OUT-OF-Network** with my current insurance

Please send protected health information as indicated to the following provider and allow communication between Girls to Women Health & Wellness, Young Men's Health and Wellness and the following provider for treatment/continuing medical care.

Provider Name: _____ **Phone:** _____

Practice/Group Name: _____

Address: _____ **Fax:** _____

Information to be disclosed. If all health information is to be released, then check only the first box.

- ☐ ALL Health Information: including Medical Summary, Immunization/Growth Charts, Lab/Radiology Reports
- ☐ Immunization Records/Growth Charts
- ☐ Lab/Radiology/Testing Reports
- ☐ Mental Health Records (excluding psychotherapy notes)
- ☐ Other (please specify): _____

Required Patient's Initials to release the following information:

____ Mental Health Records (excluding psychotherapy notes) ____ Genetic Information (including Genetic Test Results)
____ Drug, Alcohol or Substance Abuse Records ____ HIV/AIDS Test Results/Treatment

A minor individual's signature is required for the release of certain types of information , including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment.

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion and the information given above is accurate and complete to the best of my knowledge. I may revoke this authorization, in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation will be effective upon receipt by Girls to Women Health and Wellness, PA and Young Men's Health and Wellness. I have read and understand the terms of this Authorization, and hereby knowingly and voluntarily authorize Girls to Women Health and Wellness, PA and Young Men's Health and Wellness to use or disclose my health information in the manner described above. This authorization expires upon my written request.

Required Patient's Signature X_____ _____/_____/_____
Patient Signature Date

Parent/Guardian's Signature (Required for patients less than 18 years of age):

Specify relationship to patient ☐ Parent of Minor ☐ Guardian ☐ Other: _____

X _____ X_____ _____/_____/_____
Parent/Guardian (print) (if patient is a minor) Parent/Guardian Signature (if patient is a minor) Date