



AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Print Patient's Name _____

Date of Birth _____

Acct. # (internal use) _____

By signing this authorization, I authorize:

To release to:

Name _____

Name _____

Address: _____

Address: _____

City: _____ Zip _____

City: _____ Zip _____

Phone: _____

Phone: _____

the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

- | | | |
|---|--|---|
| <input type="checkbox"/> All Records | <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> Laboratory/Pathology Reports |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Operative Reports | <input type="checkbox"/> Financial Records |
| <input type="checkbox"/> Other _____ | | |

Covering the period(s) of care from _____ to _____.

I understand that information relevant to HIV testing and/or AIDS- related diagnosis(es) may be contained in this information. I understand this information may also include reference to psychiatric treatment or treatment for substance abuse.

The information will be used or disclosed for the following purpose: _____.

If requested by the patient, purpose may be listed as "at the request of the individual." The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information.

This authorization will expire on _____ not to exceed 24 months.

The information may _____ may not _____ be faxed.

I understand that I have a right to inspect and copy my own protected health information to be used or disclosed under this authorization. The Practice will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI. I understand and agree to pay a reasonable copying fee to cover the cost of transfer. I also understand that I do not have to sign this authorization in order to receive treatment from *Women Partners In OB/Gyn*. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that *Women Partners In OB/Gyn* has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at the address above.

Signed by: _____
Signature of Patient or Legal Guardian

Relationship to Patient

Print Name Legal Guardian if applicable

Date Signed

PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION