WOMEN PARTNERS
IN OB/GYN

502 Madison Oak Drive, Suite 440
San Antonio, TX 78258
Phone: 210 946-1300
Fax: 210 946-1700

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

_____ _____ _____
Patient's Name (print) Date of Birth Acct. # (internal use)

By signing this authorization, I authorize:

Name _____

Address: _____

City: _____ Zip_____

Phone: _____

To release to:

Name _____

Address: _____

City: _____ Zip_____

Phone: _____

the following individually identifiable health information about me:

☐ All Records ☐ Radiology Reports ☐ Laboratory/Pathology Reports
☐ Progress Notes ☐ Operative Reports ☐ Financial Records
☐ Other _____

covering the period(s) of care from (dates) _____to _____.
I understand that information about HIV testing, sexually transmitted disease and/or AIDS diagnosis(es) may be contained in these records. I understand these records may also reference psychiatric treatment or treatment for substance abuse.
The information will be used or disclosed for the following purpose: _____.
When 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 re-disclosure 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