**ASSOCIATES IN WOMEN'S HEALTH**
**A Division of Obstetrics & Gynecology Associates**

# Patient Authorization for Disclosure of Protected Health Information

Please print all information. Form must be signed and dated each year.

Patient Name _____ Former Name _____

Address _____

Date of Birth _____ SSN(last four digits) _____ Phone # _____

**Entity Requested to Release Information(who has the information to release):**

Individual/Entity Name: _____

Address: _____

Phone: _____ Fax: _____

**Entity Requested to Receive Information (who will be authorized to receive information)** - I authorize the entity identified above to disclose or provide protected health information, about me to the individual(s) listed below.

Individual/Entity Name: _____

Address: _____

Phone: _____ Fax: _____

How would you like your records sent? ☐ Pick up ☐ Mail ☐ Fax (We cannot email records)

**Description of information to be disclosed** - I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

☐ Patient record (last 5 years); or, check only those items of the record to be disclosed:

☐ Entire chart ☐ Office notes

☐ Lab results, pathology reports ☐ Record of HIV and communicable disease testing

☐ Ultrasound reports ☐ Record of mental health or substance abuse treatment

☐ Financial history report (previous 3 years only). ☐ Only send the following: _____

**Purpose of disclosure** (please record the purpose of the disclosure or check patient request):

☐ Patient request ☐ Transfer of care ☐ Insurance ☐ Moving ☐ Other (please specify): _____

- This authorization will expire at the end of the calendar year of your last signature below, unless you specify an earlier termination. You must renew or submit a new authorization after the expiration date to continue the authorization. Please list the date of expiration if earlier than the end of the calendar year: _____
- You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.
- The practice places no condition to sign this authorization on the delivery of healthcare or treatment.
- We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of the practice.

_____ _____

Patient or Representative Signature Date

_____ _____

If signed by Legal Representative, Relationship to patient Signature of witness