



**AUTHORIZATION TO USE/DISCLOSE HEALTH INFORMATION**

I authorize: \_\_\_\_\_

**NAME OF PHYSICIAN/CLINIC DISCLOSING INFORMATION**

To use and disclose a copy of the specific health information described below regarding:

NAME OF PATIENT	DATE OF BIRTH	PHONE NUMBER
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Consisting of:

- |  |   |
|--|---|
| <input type="checkbox"/> All Hospital Records (including nursing records and progress notes) | <input type="checkbox"/> Diagnostic Imaging Reports |
| <input type="checkbox"/> Emergency and Urgent Care Records                                   | <input type="checkbox"/> Laboratory Reports         |
| <input type="checkbox"/> Pathology Reports   | <input type="checkbox"/> Billing Statements         |
| <input type="checkbox"/> Clinician Office Chart Notes  | <input type="checkbox"/> All Medical Records        |
| <input type="checkbox"/> Other _____   |   |

To: \_\_\_\_\_ for the purpose of medical review.

**NAME OF RECIPIENT(S)**

**PHONE/FAX NUMBER**

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.

- |  |   |
|--|---|
| <input type="checkbox"/> HIV/AIDS Information      | <input type="checkbox"/> Genetic Testing Information                                |
| <input type="checkbox"/> Mental Health Information | <input type="checkbox"/> Drug/Alcohol Diagnosis, treatment, or referral information |

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict redisclosure of HIV/AIDS information, mental health information, genetic testing information, drug/alcohol diagnosis, and treatment or referral information.

You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care services if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure. Your refusal to sign this authorization does not adversely affect your enrollment in a health plan or eligibility for health benefits, unless the authorized information is necessary to determine if you are eligible to enroll in the health plan.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. Any use or disclosure already made with your permission cannot be undone.

To revoke this authorization, please send a written statement to the Release of Information Coordinator at A Woman's Time and state that you are revoking the authorization.

I have read this Authorization and I understand it. Unless revoked, this authorization **expires 180 days** from the date signed.

By: \_\_\_\_\_

**Signature of Patient /or person authorized by law**

Date: \_\_\_\_\_

Description of Representative's Authority: \_\_\_\_\_