Professionals for Women's Health

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AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient's Name_____Phone#_____
Patient's Address_____
Patient's Date of Birth_____Last 4 digits of SSN_____

I hereby authorize the USE & DISCLOSURE of my medical records:

Person/Organization Authorized to **RELEASE** Information:

Name_____
Address_____
City, State, Zip_____
Ph#_____Fax#_____

Person/Organization Authorized to **RECEIVE** Information:

Name_____
Address_____
City, State, Zip_____
Ph#_____Fax#_____

For the following protected health information:

_____ Entire Chart
_____ Other (please specify)_____

HIV, Behavioral Health, or Drug and Alcohol Abuse/Treatment information contained within the dates of service I have specified above are to be released through this authorization unless specified below:
DO NOT RELEASE: (Check all that apply) ❑ HIV ❑ Behavioral Health ❑ Drug/Alcohol

Delivery Options. Please choose **ONE**:

_____ Paper copy of information via US Mail using the address listed above
_____ Fax the requested information to the fax number listed above
_____ Release records to MyChart

I am requesting my records to be disclosed for the following purpose:
_____

This authorization expires ninety (90) days from signature, or at the following event: _____
I may revoke this authorization at any time by mailing or personally delivering a signed, written notice of revocation to the healthcare provider at which this authorization was executed. Such revocation will be effective upon receipt, except to the extent that the recipient has already taken action in reliance on this authorization. I am entitled to a copy of this authorization upon my request. I may not be required to sign this authorization as a condition to obtaining treatment or payment or my eligibility for benefits. The recipient of this protected health information is prohibited from re-disclosing the information unless the recipient obtains another authorization for me or unless the disclosure is specifically required or permitted by law. Where permitted, the information I am requesting to be disclosed may sometimes be re-disclosed by the recipient and may no longer be protected by law. I am entitled to notice if my protected health information is used for marketing and results in remuneration to the provider. I hereby acknowledge that I have read and fully understand the above statements as they apply to me.

Right to Request Information

I understand that I have the right to inspect or obtain a copy of my personal health information (PHI) maintained by Professionals for Women's Health. I understand that Professionals for Women's Health will make every reasonable effect to provide me access to my protected health information. Professionals for Women's Health may provide a summary, in lieu of providing access to the protected health information requested, or may provide an explanation of the protected health information to which access has been provided, if I agree in advance to the summary, and if I agree in advance to the fees imposed for such summary. The fee for copying my protected health information includes the costs of supplies and labor for copying or for preparing an explanation, or summary, if agreed, and postage, if applicable.

Request Fulfillment

I understand that, if approved, the requested records:

1) Will be furnished in a form or format that is acceptable to me, if readily reproducible in that form or format; or, if not, in a readable hard copy form;
2) Will be furnished as quickly as possible, but no later than 30 days after the request was submitted, (or 60 days if the information is maintained off-site, or if the Plan notifies me within 30 days that it needs a one-time extension for no more than an additional 30 days);
3) May be furnished by a Business Associate who stores and maintains the requested records.

I understand that I may be charged a reasonable fee for copying the requested records and mailing the records (if requested).

Signature

_____ _____

Signature of Individual or Individual's Personal Representative Date (mm/dd/yyyy)

If signed by a Personal Representative, please complete the information below:

_____

Signature of Personal Representative Relationship to Individual

_____

Personal Representative's Address City State Zip

_____

Personal Representative's Area Code & Telephone Number Personal Representative's