Phone: (772) 219-1080
Fax: (772) 219-1070

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION <u>TO</u> WOMEN'S HEALTH SPECIALISTS

By signing this authorization, I authorize ____(“Prior Health Care Provider”) to use and/or disclose certain protected health information (PHI) about me to _____________________________________ at Women's Health Specialists, 3498 NW Federal Highway, Jensen Beach, FL 34957.

This authorization permits the Prior Health Care Provider to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of service, level of detail to be released, origin of information, etc.).

____

____

The information will be used or disclosed for continuing medical care. The purpose is provided so that I can make an informed decision whether to allow release of the information.

This authorization will expire on 30 days from the date I sign this form or ______________________.
(Expiration Date or Defined Event).

I do not have to sign this authorization in order to receive treatment from Prior Health Care Provider. 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 will be Protected Health Information and subject to the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Prior Health Care Provider.

Signed by:______________________________ ______________________________
Signature of Patient or Legal Guardian Relationship to Patient

______________________________ ______________________________
Patient's Name Date

______________________________ ______________________________
Print Name of Patient or Legal Guardian Patient Date of Birth

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