Name of Clinic/Doctor-

Phone Number-

Fax Number-

Women's Health
OF THE EMERALD COAST

Authorization for Use and/or Disclosure of Protected Health Information

Patient Identification
Printed Name:_____ Date of Birth:_____
Address:_____
_____

Social Security #: _____ Telephone: _____

Information to be released-Covering the Periods of Health Care
From (date) _____ to (date) _____
From (date) _____ to (date) _____

Please check type of information to be released:

- ☐ Entire medical record
- ☐ Operative Report
- ☐ Consultation Report
- ☐ History and Physical exam
- ☐ X Ray reports/image
- ☐ Itemized bill
- ☐ Laboratory/Pathology results/report
- ☐ Other_____

Purpose of Request:
☐ Treatment or Consultation ☐ At patient request ☐ Billing
☐ Other (specify) _____

Person Authorized to Receive Information
Name: _____
Address: _____
Phone: _____

Drug and/or Alcohol Abuse and/or Psychiatric, and/or HIV/AIDS Records Release
I understand that if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/ or other sensitive information I agree to its release ☐ yes ☐ no
_____initials

I understand that if my medical or billing record contains information in reference to HIV/AIDS testing and or treatment, I agree to its release ☐yes ☐ no _____initials

Time Limit and Right to Revoke Authorization
Except to the extent that action has already been taken in reliance on this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of patient or personal representative who may request disclosure
I understand that Women's Health of the Emerald Coast may not condition my treatment on whether I sign this authorization from unle specified above under Purpose of Request. I can inspect or copy the protected health information to be used or disclosed.
I authorize _____ to use and disclose the protected health information specified above.
(name of facility)

SIGNATURE: _____
DATE: --_____