Patient Authorization for Use and Disclosure of Protected Health Information

1. By Signing this for I Authorize:

   Physicians and Surgeons for Women
   1821 East High St.
   Springfield, Ohio 45505

2. To use and /or disclose certain protected health information (PHI) about me to:
   Name of Physician, Facility, or other Entity_____
   Mailing Address: _____
   City_____ State _____ Zip_____
   Phone: _____ Fax: _____

   For the Purpose of:
   _____ Continuity of Care (i.e. To a specialist or family doctor)
   _____ Transfer of care to another physician
   _____ Insurance reasons
   _____ Attorney / Court Case
   _____ On site review of my medical file by _____
   _____ HEDIS report for insurance
   _____ Personal reasons
   _____ Other Please Specify: _____

3. The type and amount of information to be used and disclosed is as follows (check appropriate lines and include dates where appropriate)

_____ Office Notes:	Beginning Date of: _____ Through _____
_____ Laboratory results	Beginning Date of: _____ Through _____
_____ Pap results, cultures, pathology, or reports	Beginning Date of: _____ Through _____
_____ Hospital records & notes	Beginning Date of: _____ Through _____
_____ Mammogram, x-ray, or radiology reports	Beginning Date of: _____ Through _____
_____ Entire medical record	Beginning Date of: _____ Through _____
_____ Entire medical record with no exclusions	
_____ Other: Please specify _____	
_____	

4. I understand that the information in my health record may include information relating to sexually transmitted disease, AIDS, or HIV. It may also contain information about behavioral or mental health services and treatment for alcohol and drug abuse.
5. I understand that I have the right to revoke this authorization at any time**. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the privacy officer at Physicians and Surgeons for Women Inc.** I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation does not apply to my insurance company when the law provides my insurance with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire one year from this signature date.**
6. I understand that I do not have to sign this form in order to receive treatment from Physicians and Surgeons for Women Inc. I have the right to refuse to sign the authorization. When my information is used or disclosed pursuant to the authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.
7. **By transferring care, I understand that I have the right for Emergent Care only for 30 days from the date of this consent. I understand that I will no longer be scheduled for appointments unless emergent and then only when and if approved by my physician.**

Patients Name: (please print)_____ Patient DOB_____

Patient or Legal Guardian Signature_____ Date_____

If Signed by a Legal representative, relationship to patient_____