My WOMEN'S CENTER

Gyn. Health. Beauty. Joy.

Patient Authorization for Use and Disclosure
Of Protected Health Information

By Signing this authorization, I authorize My Women's Center to use and/or disclose certain protected health information (PHI) about me,

To:_____ From:_____

_____ _____

_____ _____

This Authorization permits My Women's Center 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 services, type services, level of detail to be released, origin of information, etc.) :

_____

The information will be used or disclosed for the following purpose:

_____

If requested by the patient, purpose may be listed as "at the request of the individual." The purpose(s) is/are provided so that I can make and informed decision whether to allow release of the information. This authorization will expire on _____. (Authorizations valid for 30 days)

The practice will ____ will not ____ receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.
I do not have to sign this authorization in order to receive treatment from Reno Gynecology. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPPAA 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 Privacy Officer at our office.

Signed by: _____ _____
Signature of patient or legal Guardian Relationship to Patient

_____ _____ _____
Patient Name (Please Print) Date of Birth Today's Date

_____
Printed Name of Legal Guardian (If Any)

Patient/Guardian to be provided with a signed copy of Authorization

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