Authorization for Women's Healthcare of Princeton to Release My Health Care Information

Patient Name:_____(DOB):_____

Previous Name:_____

I. My Authorization

You may use or disclose the following health care information (check all that apply):

- ☐ All health care information in my medical record
- ☐ Health care information in my medical record relating to the following treatment or condition:_____
- ☐ Health care information in my medical record for the date(s):_____
- ☐ Other (e.g., X-rays, bills), specify date(s):_____

You may use or disclose health care information regarding testing, diagnosis, and treatment for (check all that apply):

☐ HIV (AIDS virus) ☐ Sexually transmitted disease ☐ Drug and/or alcohol use

You may disclose this health care information to:

Name(or title) and organization:_____

Address:_____ City:_____ State:_____ Zip:_____

Facsimile #_____Phone # _____

Reason(s) for this authorization (check all that apply):

- ☐ ☐ at my request ☐ other specify)_____
- ☐ ☐ check only if Women's Healthcare of Princeton requests for marketing purposes
- ☐ ☐ check only if Women's Healthcare of Princeton will be paid or get something of value for providing health information for marketing purposes

This authorization ends: ☐ **on (date):**_____

☐ when the following event occurs:_____

A photocopy of this instrument may be used instead of the original.

II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- To take part in a research study or
- To receive health care when the purpose is to create health care information for a third party

(over)

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I may revoke this authorization in writing at any time. If I did, it would not affect any actions already taken by Women's Healthcare of Princeton based upon this authorization. Two ways to revoke this authorization are:

- Fill out a revocation form (form is available from Women's Healthcare of Princeton)
- Write a letter to Women's Healthcare of Princeton

I understand that there is a risk that the person or organization receiving my health care information could possibly redisclose it without my authorization.

_____ _____

Patient or legally authorized individual signature Date Time

_____ _____

Printed name if signed on behalf of the patient Relationship (parent, legal guardian, or personal representative)

\bcb