shea
WOMEN'S CARE
OBSTETRICS AND GYNECOLOGY

Authorization for Disclosure of Health Information

Patient Name: _____

Date of Birth: _____

I authorize the disclosure and release of medical record information as well as billing information to the individual named below.

Name: _____

Date of Birth (for identification purposes): _____ Relationship: _____

1. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate).

   _____ Complete health records
   _____ Lab results/X-ray reports
   _____ Physical exam
   _____ Consultation reports
   _____ Immunization record
   _____ Billing/Statement balances and details
   _____ Other (please specify: _____

2. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

3. I understand that I have a 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 practice. I understand that the revocation will apply solely to the individual named in this document and does not apply to my insurance company or any other entity who may be entitled to claim information or records as detailed in the HIPAA privacy policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:
   _____.

4. If I fail to specify an expiration date, event or condition, this authorization will expire in 365 days. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact:

   Monica Frazer, Privacy Officer for Shea Women's Care _____ .

_____ _____

Signature of patient or legal representative | Signature of witness

Date: _____ Date:_____

PLEASE NOTE: This information has been disclosed to you from confidential records protected from disclosure by state and federal law. No further disclosure of this information should be done without specific, written and informed release of the individual to whom it pertains or as permitted by state law (ORC – 3701.243) and federal law 42 CFR, part II.