TO: _____

_____

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

(Note: *DO NOT USE THIS FORM IF RECORDS RELATE TO HIV TEST RESULTS*)

Explanation: This authorization is necessary for us to comply with state and federal laws pertaining to the use or disclosure of protected health information ("PHI") about the patient identified below. Please provide all requested information. Failure to provide requested information may be detrimental to our patient.

Name of Patient: _____ Other Names (a.k.a.) _____ Date of Birth _____

1. **PERSONS AUTHORIZED TO DISCLOSE PHI**: I authorize the following person(s) or class of persons to disclose the health information about patient as described in Section below: (State name of physician or specific identification of person or class or persons.)

2. **DESCRIPTION OF INFORMATION**: This Authorization permits for use and/or disclosure of the following information about patient:
[ ] All the information contained in my medical record. Except (optional) _____
Or, only the records for the following dates or types of health information:
Date(s) of Treatment: _____ Type of Treatment: _____
Or, Other _____

3. **AUTHORIZED USES AND RECIPIENTS**: I hereby authorize the following persons or class of persons to receive and/or use the health information described in Section 2 above: (State name and title, if applicable.)

THE WOMEN'S HEALTH CENTER
9940 Talbert Avenue, Suite 303, Fountain Valley, California 92708 Telephone: 714-378-5606 Fax: 714-378-5621

4. **PURPOSE**: I hereby authorize the information check in Section 2 above to be used and/or disclosed for the following purposes. (Check all applicable.)
[ ] Requested by patient or personal representative. [ ] Others: _____
Physician or Practice will be remunerated for this information: [ ] Yes [ ] No (No authorization needed for release for research purposes.)

5. **RIGHT OF REVOCATION**: I understand that I have the right to revoke this Authorization at any time, providing that my revocation is in writing and conforms to requirements described in the Notice of Privacy Practices of The Women's Health Center.

6. **LIMITS TO REVOCATION**: I understand that my revocation will be effective upon its receipt by the person(s) I authorized in Section 1 but would not be effective to the extent that such persons have acted in accordance with this Authorization and in reliance thereon. With respect to the person(s) I authorized to receive and use health information described in Section 3, if patient (or personal representative) requested the Authorization, any revocation will be effective only when I communicate my revocation directly to them.

7. **REDISCLOSURE**: I understand that if the recipient of my information in Section 3 is not a healthcare provider, a health plan or a health care clearing house or not an entity required to comply with federal or state health privacy regulations, my health information may be further disclosed by such recipient and my information may no longer be protected by state and federal laws. If this Authorization is for the disclosure of substance abuse information, the recipient may be prohibited from disclosing the substance abuse information under federal substance abuse confidentiality requirements.

8. **CALIFORNIA RESTRICTION**: I understand that a recipient of medical information in California may not further disclose medical information about me (patient) unless a new Authorization form is signed by me or my personal representative or unless the disclosure is specifically required or permitted by law.

9. **RIGHT TO REFUSE TO SIGN**: I understand that I do not have to sign this Authorization and that my failure to sign this Authorization will not affect my ability to obtain treatment, payment or benefits.

10. **AUTOMATIC ONE-YEAR DURATION**: This Authorization will automatically expire after one (1) year from the date of execution unless a different end date or event is specified. **End date:** _____ ***or*** **Event**: _____

11. **COPY RECEIVED**: I acknowledge receipt of a signed copy of this Authorization. _____ (initials)

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Print Name of Personal Representative (if applicable) Relationship of Personal Representative to Patient

_____ _____
Address of Personal Representative Telephone Number of Personal Representative

ATTENTION RECIPIENT: ANY DISCLOSURE OF MEDICAL RECORD INFORMATION BY THE RECIPIENT IS PROHIBITED EXCEPT WHEN IMPLICIT IN THE PURPOSE OF THIS DISCLOSURE.