PARTNERS IN WOMEN'S HEALTH

STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The information to be used or disclosed by this authorization includes:

Please check the line for information you want disclosed:

_____ Reason and Description for Visit
_____ Reason and Description for Consult
_____ Reason and Description for any other type of visit whether office or another location not listed above
_____ Reason and Description for Procedure
_____ Reason and Description for Surgery
_____ Reason and Description for Labs ordered
_____ Reason and Description for Pathology
_____ Reason and Description for Ultrasound
_____ Reason and Description for any other special testing not mentioned above
_____ Lab Results
_____ Pathology Results
_____ Culture Results
_____ Ultrasound Results
_____ Test Results for all other items Not Listed Above
_____ Reason for and type of sample prescriptions given
_____ Reason for and type of prescriptions given

I authorize any Physician, Nurse Practioner or Medical Assistant within the organization of Partners In Women's Health to disclose the information checked above

Name of Person(s) authorized to receive the information checked above

_____
Name and Relationship to Patient

_____
Name and Relationship to Patient

_____
Name and Relationship to Patient

_____
Name and Relationship to Patient

Please check below if you will allow:

_____Entrance into the exam room during exam
_____Entrance into procedure room during procedure
_____Entrance into Ultrasound room during Ultrasound

_____
Name and Relationship to Patient

_____
Name and Relationship to Patient

_____
Name and Relationship to Patient

_____
Name and Relationship to Patient

Expiration Date of Authorization
This authorization is effective through _____/_____/_____ unless revoked or terminated earlier by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to Partners In Women's Health. You should contact the Privacy Officer to terminate this authorization.

Potential for Re-Disclosure
Information disclosed under this authorization may be disclosed again by the person(s) or organization to which receives it. It may not be possible to ensure your right to the protection of the privacy of this information once Partners In Women's Health discloses it to another party.

Effect of Refusing Authorization
If you refuse to sign this authorization, Partners In Women's Health will not deny you any treatment except research-related treatment or treatment that you have requested for the purpose of disclosure to others.

_____ **Date**
Patients Signature

_____ **Date**
Witnessed By (Employee of Partners In Women's Health)

PARTNERS IN WOMEN'S HEALTH

Acknowledgement of Receipt of Notice of Privacy Practices

Partners In Women's Health reserves the right to modify the privacy practices outlined in the notice.

Signature

I have received and read a copy of the Notice of Privacy Practices for Partners In Women's Health

_____

Name of Patient (Print)

_____

Signature of Patient Date

_____

Signature of Patient Representative Date
(Required if the patient is a minor or an adult who is unable to sign this form)

_____

Relationship of Patient Representative to Patient Date

(IF APPLICABLE - MINOR AND GUARDIAN)

I HAVE BEEN INFORMED OF THE RIGHTS OF A MINOR PATIENT AND THE PRIVACY OF THEIR RECORDS. I HAVE ALSO BEEN INFORMED OF THE RIGHT OF A MINOR TO COMPLETE A AUTHORIZATION FORM IN ORDER FOR PARTNERS IN WOMEN'S HEALTH TO DISCLOSE PRIVATE HEALTH INFORMATION TO DESIGNATED PERSON(S).

WILL YOU BE AUTHORIZING PARTNERS IN WOMEN'S HEALTH TO DISCLOSE YOUR HEALTH INFORMATION TO A DESIGNATED PERSON(S).

Please check: Yes_____(Attached) No_____
Patient Initials Patient Initials

_____

Signature Of Minor Date

_____

Signature of Legal Guardian or Patient Representative) Date

_____

Witnessed By (Employee of Partners In Women's Health) Date