Patient Authorization for Use and Disclosure of Protected Health Information

Today's Date: Month / Day / Year

Patient Last Name:

Patient First Name:

Patient Middle:

Date of Birth: Month / Day / Year SSN#:

By checking the agree box on the next page, I authorize: Enter name of facility

Facility phone number:

Facility Address:

City: Sate: Zip:

to use and/or disclose the following Protected Health Information (PHI) (check all that apply):

- ☐ All healthcare information in my medical record.
- ☐ Healthcare information in my medical record relating to the following treatment or condition:
- ☐ Healthcare information in my medical record for the following date(s) Month / Day / Year
  Month / Day / Year
  Month / Day / Year
- ☐ Other (for example; x-rays, bills), specify dates(s) Month / Day / Year
  Month / Day / Year
  Month / Day / Year

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

- ☐ HIV
- ☐ Sexually transmitted diseases
- ☐ Drug and/or alcohol abuse
- ☐ Psychiatric disorders/mental health

You may disclose this information to:

Name (or title):

Orgazination:

Address:

City:

State: Zip:

Reason for this authorization (check all that apply):

- ☐ At my request
- ☐ Check only if practice requests authorization for marketing purposes
- ☐ Check only if practice will be paid or get something of value for providing health information
- ☐ Other (Please specify): _____

This authorization ends: (This document does not permit disclosure of health information created more than 90 days after the date it is signed.)

- ☐ Month ____ / Day ____ / Year ____
- ☐ in 90 days from the date signed
- ☐ When the following event occurs: _____

My Rights:

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

- To take part in a research study
- To receive healthcare when the purpose is to create healthcare information for a third party.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Lakewood Women's HealthCare based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- Fill out a revocation form. This form is available on our forms page.
- Write a letter to Lakewood Women's HealthCare.

I understand that by clicking the "I agree" box below, I am giving legal consent for disclosure of my healthcare information, as specified in this form. Once healthcare information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

Name of patient or legal guardian — First Name _____ Last Name _____

Relationship to patient: _____

☐ I agree to the terms above

Date: Month ____ / Day ____ / Year ____

Signature: _____