OB/GYN Centre of Excellence

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AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT NAME: ________________________________ **DOB:** ___/___/____ **SS#:** ______________

I, ______________________________, do hereby authorize OB/GYN Centre of Excellence, P.C. to:
(Patient's or personal representative's name)

☐ Obtain information from: ☐ Disclose information to:

____
(Name of Person or Agency)

____
(Address of Person or Agency)

This authorization is applicable only to the information, time period or event(s) indicated below:

The following information may be used/disclosed:	
X Face Sheet/Basic Demographic Information	X Reports pertaining to tests and X-rays
X History and Physical Records	X Treatment Records
X Inpatient/Outpatient Records	☐Other: ______________

Specific Time Period or Event:

- ☐ Any/all dates of service
- ☐ Services/treatment received within past twelve months
- ☐ Other (must specify): ______________________________

The purpose for the use/disclosure of this information is to provide services to the above-mentioned patient.

I understand that I may revoke this authorization at any time by notifying OB/GYN Centre of Excellence in writing. However, I also understand the revocation of this authorization is not valid until received by OB/GYN Centre of Excellence and has no effect on actions already taken on it prior to revocation. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain services.

I understand that information disclosed to OB/GYN Centre of Excellence from the person or agency identified above will be held strictly confidential and cannot be released again without my written authorization unless otherwise permitted by law. However, if neither federal or state privacy laws or regulations apply to the recipient of the information, I understand that the information disclosed by OB/GYN Centre of Excellence pursuant to this authorization may be re-disclosed by the recipient and would no longer be protected by federal or state privacy laws or regulations.

This information I authorize for use or disclosure may include information relating to communicable diseases including, but not limited to, diseases such as hepatitis, syphilis, gonorrhea, and acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). I have read the foregoing applicable statements on this authorization for use/disclosure of my protected health information, and I fully understand its contents.

Patient's Signature: ______________________________ Signature Date: ______________

Personal Representative's Signature: ______________________ Relationship: ______________

Witness: ______________________ Title or Relationship to Person Served: ______________

Expiration Date/Event: ______________________________
(This authorization will automatically expire six (6) months from the signature date.)