FOR WOMEN HEALTH CARE
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Obstetrics & Gynecology

Authorization Form For Release of Protected Health Information

By signing this form, I authorize you to use and disclose the protected health information described below.

Patient Name: _____ Date of Birth: _____

The health information you may release subject to this authorization is as follows:

_____

_____

Release my protected health information to the following person(s) entity:

Name: _____ Relation _____ Name: _____ Relation _____

Street: _____ Street: _____

City: _____ State: ____ Zip: _____ City: _____ State: _____ Zip: _____

Phone: _____ DOB: _____ Phone: _____ DOB: _____

The reasons or purposes for this release of information are as follows:

_____

_____

_____

This authorization shall be in force and effective until the following event and/or date: _____

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to the following person:

Privacy Officer: Enny Olowookere
For Women Healthcare
2110 W. Michigan Ave
Midland, TX 79701

I understand that a revocation is not effective to the extent that the practice has relied on this authorization in its actions. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy of policy itself.

I understand that information used or disclosed pursuant to this authorization may be to redisclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations. **The practice will not condition my treatment, payment, and enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.**

_____ _____

Signature of Patient Signature of Personal Representative

_____ _____

Date Description of Personal Representative's Authority