The Women's Health Group, P.A.
Obstetrics and Gynecology

HIPAA Privacy Authorization Form

****Authorization for Use or Disclosure of Protected Health Information* ***

(Required by Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

I authorize The Women's Health Group to use and disclose the protected health information described below to ____.

Relationship to patient ____

a. □ I authorize the release of my complete health record.
b. □ I authorize the release of my complete health record with the exception of the following information:____
____
c. □ I do not wish to release any of my health record to anyone.

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

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Signature of patient or personal representative

____ ______________________________

Printed name of patient or personal representative Date