AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I. I hereby authorize (name of physician/provider):

Name: ______________________

Address: ______________________

City ______________ State ______ Zip ________

TO: Center for Women's Health -Salisbury
659 S. Salisbury Blvd., Suite 4
Salisbury, MD 21801
Phone: 410-543-9111 **Fax:** 410-543-9115

II. To Release the Following Information:

Attn: ___*Medical Records*______________

Patient Name: ______________________ **DOB:** ______________________

Address: ______________________ **SS #:** ______________________

City: ______________ **State:** ______ **Zip:** __________

III. Information Requested:

Date of Treatment: FROM ______________________ TO ______________________

Category of PHI (please check)

☐ Progress Notes ☐ Insurance/Correspondence ☐ Medical Imaging Reports/EKG ☐ Immunizations

☐ Medical History ☐ Laboratory Results ☐ Consults/Hospital Reports ☐ Demographic

☐ All Records

You must specifically request disclosure of the following categories:

☐ **HIV Test Results** ☐ **Drug/Alcohol Test Results** ☐ **Mental Health Records**

IV. Authorization

☐ I would like this authorization to expire on/or after the date/event listed: ______________________

☐ I understand this authorization is only valid for ***60 days*** from the date of signature if I do not specify a date. I understand that I may revoke this consent at any time, in writing, but not retroactive to the release of information made in good faith. I understand the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by the HIPAA privacy rule. I understand that treatment, payment or other benefits cannot be conditioned on the execution of the Authorization.

Signature: ______________________ **Date**: ______________________

Printed Name: ______________________

If not signed by the patient, please indicate relationship:

☐ Parent, guardian or caregiver of a minor patient.

☐ Guardian or conservator of an incompetent patient.

☐ Beneficiary or personal representative of a deceased patient.

☐ Other ______________________ [SPECIFY RELATIONSHIP]

*** PLEASE COMPLETE AND FAX TO 410-543-9115 ***