



# AUTHORIZATION TO DISCLOSE INFORMATION

1. I, (Patient Name) \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Authorize the use and disclosure of the listed individual's health information as described below. I understand that I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed.

2. a. Disclosures (from) PARTNERS IN WOMEN'S HEALTH  
 \_\_\_\_\_ FROM \_\_\_\_\_ TO (Full name and address of individual or agency)  
 PARTNERS IN WOMEN'S HEALTH  
 3940 DUPONT CIRCLE  
 LOUISVILLE, KY 40207  
 PHONE (502) 895-1111  
 FAX (502) 895-1085

b. Disclosures (to) PARTNERS IN WOMEN'S HEALTH  
 \_\_\_\_\_ TO \_\_\_\_\_ FROM (Full name and address of individual or agency)  
 PARTNERS IN WOMEN'S HEALTH  
 3940 DUPONT CIRCLE  
 LOUISVILLE, KY 40207  
 PHONE (502) 895-1111  
 FAX (502) 895-1085

3. I understand that the purpose of this disclosure is for:  
 \_\_\_\_\_ Use in future treatment  
 \_\_\_\_\_ Other (specify) \_\_\_\_\_

4. The type of information to be used or disclosed is as follows: (include dates where appropriate)

Office Records       Laboratory Test(s)       History/Physical       Treatment Plan  
 Medication History       Discharge Summary       Operative Report       Diagnosis/Dates of Treatment  
 Alcohol and Other Drug Use, Abuse and/or Treatment Information       Treatment Information which may include Human Immunodeficiency Virus (HIV) Infection, Acquired Immunodeficiency Syndrome (AIDS), or tests for HIV.

5. Any person who received mental health or chemical dependency patient information is prohibited by KRS 304.17A.555 from redisplaying that information without specific written consent of the patient. However, Partners In Women's Health cannot prevent the re-disclosure of information by the recipient and the potential exits that information disclosed pursuant to the authorization will be re-disclosed by the recipient.

6. If this information being requested is from an alcohol or drug treatment case 42 C.F.R. Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records applies: This information has been disclosed to you from records protected by Federal confidentiality rules. The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

7. I understand that I have a right to revoke this authorization at any time. To revoke this authorization, I must do so in writing and present my written revocation to the health information management personnel. I understand that the revocation will not apply to information that has already been released in response to this authorization or information disclosed for the purpose of receiving reimbursement from a third party payer.

8. Unless otherwise revoked, this authorization will expire one year from the date signed \_\_\_\_\_ (Date)  
 or after the following event has occurred or condition has been met \_\_\_\_\_

\_\_\_\_\_  
 Patient / Personal Representative Signature      Date

\_\_\_\_\_  
 Witness / Staff      Date

Personal Representative's Authority

Parent       Spouse       Adult Child

Other \_\_\_\_\_