



PARTNERS IN WOMEN'S HEALTH

STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The information to be used or disclosed by this authorization includes:

Please check the line for information you want disclosed:

- Reason and Description for Visit
- Reason and Description for Consult
- Reason and Description for any other type of visit whether office or another location not listed above
- Reason and Description for Procedure
- Reason and Description for Surgery
- Reason and Description for Labs ordered
- Reason and Description for Pathology
- Reason and Description for Ultrasound
- Reason and Description for any other special testing not mentioned above
- Lab Results
- Pathology Results
- Culture Results
- Ultrasound Results
- Test Results for all other items Not Listed Above
- Reason for and type of sample prescriptions given
- Reason for and type of prescriptions given

I authorize any Physician, Nurse Practitioner or Medical Assistant within the organization of Partners In Women's Health to disclose the information checked above

Name of Person(s) authorized to receive the information checked above

Name and Relationship to Patient

Name and Relationship to Patient

Name and Relationship to Patient

Name and Relationship to Patient

Please check below if you will allow:

- Entrance into the exam room during exam
- Entrance into procedure room during procedure
- Entrance into Ultrasound room during Ultrasound

Name and Relationship to Patient

Name and Relationship to Patient

Name and Relationship to Patient

Name and Relationship to Patient

Expiration Date of Authorization

This authorization is effective through ____/____/____ unless revoked or terminated earlier by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to Partners In Women's Health. You should contact the Privacy Officer to terminate this authorization.

Potential for Re-Disclosure

Information disclosed under this authorization may be disclosed again by the person(s) or organization to which receives it. It may not be possible to ensure your right to the protection of the privacy of this information once Partners In Women's Health discloses it to another party.

Effect of Refusing Authorization

If you refuse to sign this authorization, Partners In Women's Health will not deny you any treatment except research-related treatment or treatment that you have requested for the purpose of disclosure to others.

Patient's Signature

Date

Witnessed By (Employee of Partners In Women's Health)

Date