Authorization for Use or Disclosure of Protected Health Information

COMPLETE ALL SECTIONS, DATE, AND SIGN

I. I, or my legally authorized representative acting on my behalf, authorize the disclosure of my protected health information as described in this authorization.

Patient Name: _____ Birthdate: _____ SSN (Last 4 digits):_____

II.

The information is to be disclosed by:	**And is to be provided/sent to:**
NAME OF FACILITY	NAME OF PERSON/ORGANIZATION/FACILITY Associated Surgeons & Physicians dba Women's Health Advantage/Center for Colon & Rectal Care
ADDRESS	ADDRESS 2518 E Dupont Rd 7988 W Jefferson Blvd
CITY, STATE, ZIP	CITY, STATE, ZIP Fort Wayne, IN 46825 Fort Wayne, IN 46804

III. Purpose or need for this disclosure is:

[ ] Treatment [ ] Legal [ ] Research [ ] School/Educational Institution
[ ] Employment [ ] Insurance [ ] Disability [ ] At the Request of the Individual [ ] Other_____

IV. Information to be disclosed from my medical record *(Check appropriate box(es))*:

[ ] Only information related to (specify) _____
_____
[ ] Only for dates of service from _____ to_____
[ ] Other (specify) (ex: radiology, billing, etc.)_____
[ ] Entire Record (includes all information in the designated record set)

V. If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

[ ] HIV/AIDS Testing & Treatment
[ ] Genetic Testing
[ ] Mental Health *(Other than Psychotherapy Notes)*
[ ] Sexually Transmitted Diseases
[ ] Sexual & Reproductive Health
[ ] Substance Use Disorder Records (Treatment/Referral/Billing protected under 42 CFR Part 2; additional restrictions on redisclosure apply)

VI. Format: I request that a copy be provided (where possible/available):

[ ] Paper [ ] email:_____
[ ] Other: _____

VII. I understand that this authorization is voluntary and that my treatment, payment, health plan enrollment, or eligibility for benefits will not be conditioned on my signing it.

VIII. I understand that the information disclosed under this authorization may be redisclosed by the recipient and may no longer be protected by federal privacy regulations, except for Substance Use Disorder treatment/referral records protected under 42 CFR Part 2.

IX. I may revoke this authorization by notifying the disclosing facility in writing of my desire to revoke it. However, I understand that any actions already taken based on this authorization cannot be reversed and my revocation will not affect those actions. Additionally, if this authorization was obtained as a condition of obtaining insurance coverage, other law may provide the insurer with the right to contest a claim under the policy.

X. This authorization expires on _____, 20_____, OR upon the following event:
_____. If no date or event is specified, the authorization will automatically expire one (1) year from the signature date.

_____ _____
SIGNATURE OF PATIENT *DATE*

_____ _____
SIGNATURE OF PERSONAL REPRESENTATIVE & RELATIONSHIP TO PATIENT / AUTHORITY TO ACT (e.g., legal guardian, healthcare POA, parent of minor) *DATE*

_____ _____
SIGNATURE OF WITNESS (If signature of patient is a thumbprint or mark) *DATE*

datavant

Fax (678) 710-2559