SOUTHWESTERN OB/GYN

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, ____, authorize SOUTHWESTERN OB/GYN to:

(Check all that apply.)
❏ use the following protected health information, and/or

❏ disclose the following protected health information to: (List name of person or entity to receive information.)

____

____

The protected health information to be used and/or disclosed is as follows:
(Provide a meaningful and specific description of the information.)

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This protected health information is to be used and/or disclosed for the following purpose(s): (Provide description of specific purpose(s).)

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I understand that I may inspect or copy the information used or disclosed under this authorization.

I understand that if the person or entity who receives my protected health information is not covered by the Federal health care privacy regulations, the personal health information disclosed may be re-disclosed to another person or entity and it will no longer be protected by the Federal health care privacy rules.

I understand that SOUTHWESTERN OB/GYN may receive compensation for the use or disclosure of my protected health information.

I understand that I may refuse to sign this authorization and that this refusal will not affect my ability to obtain health care treatment from SOUTHWESTERN OB/GYN, payment for this treatment, or my ability to enroll in a health care plan or be eligible for health care plan benefits.

I understand that I have the right to revoke this authorization at any time, in writing, by notifying SOUTHWESTERN OB/GYN's Privacy Officer, except to the extent that SOUTHWESTERN OB/GYN has relied upon the authorization.

This authorization expires on ____

____________________________________ ____________________________________

Signature of patient or legal representative   Printed name of patient or legal representative

Relationship to patient ________________________________   Date ____________________

Source: American Hospital Association