CLINIC APOTHECARY

A WOMAN'S TIME

MENOPAUSE OPTIONS & NATURAL MEDICINE

222-2322

*Please fax records that are fewer than 25 pages.

If 26 pages or more, please mail.

Thank you.*

AUTHORIZATION TO USE/DISCLOSE HEALTH INFORMATION

I authorize: _____

NAME OF PHYSICIAN/CLINIC DISCLOSING INFORMATION

To use and disclose a copy of the specific health information described below regarding:

_____

NAME OF PATIENT **DATE OF BIRTH** **PHONE NUMBER**

Consisting of:

___ All Hospital Records (including nursing records and progress notes)
___ Emergency and Urgent Care Records
___ Pathology Reports
___ Clinician Office Chart Notes
___ Other _____

___ Diagnostic Imaging Reports
___ Laboratory Reports
___ Billing Statements
___ All Medical Records
Please Disclose by_____

To: _____ for the purpose of medical review.

NAME OF RECIPIENT(S) **PHONE/FAX NUMBER**

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.

___ HIV/AIDS Information
___ Genetic Testing Information
___ Mental Health Information
___ Drug/Alcohol Diagnosis, treatment, or referral information

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict redisclosure of HIV/AIDS information, mental health information, genetic testing information, drug/alcohol diagnosis, and treatment or referral information.

You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care services if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure. Your refusal to sign this authorization does not adversely affect your enrollment in a health plan or eligibility for health benefits, unless the authorized information is necessary to determine if you are eligible to enroll in the health plan.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. Any use or disclosure already made with your permission cannot be undone.

To revoke this authorization, please send a written statement to the Release of Information Coordinator at A Woman's Time and state that you are revoking the authorization.

I have read this Authorization and I understand it. Unless revoked, this authorization **expires 180 days** from the date signed.

By: _____ Date: _____

Signature of Patient or person authorized by law

Description of Representative's Authority: _____

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