



Southern Maryland Women's Healthcare, P.A.

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**PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF
PROTECTED HEALTH INFORMATION**

Patient Name _____ DOB _____

1. **Authorization:** By signing this Authorization, I authorize Southern Maryland Women's Healthcare to use, disclose to and/or obtain from the person or entity named below my (my child's) protected health information described below ("PHI").

Disclose (send) my information to (print full name and address): _____

Obtain my information from (print full name and address): _____

Description of information (specifically describe the information to be used or disclosed, such as dates of service, type of service, level of detail to be released, origin of information, etc.): _____

_____ **DO** release HIV/AIDS and/or sexually transmitted disease-related and/or psychological or psychiatric treatment and/or drug/alcohol abuse or treatment information, if applicable. I understand that this is a dual release inclusive of sensitive medical information, including HIV.

_____ **DO NOT** release the following information _____

2. **Purpose:** This information will be used or disclosed for the following purpose(s): _____

(If requested by the patient (or patient's parent/personal representative), purpose may be listed as "at the request of the individual.")

3. **Limitations:** In addition to the above, the following is/are other criteria or limitations that I make regarding this Authorization:

4. **Expiration Date/Event:** This Authorization is valid until ___/___/___ or until the following event: (e.g., completion of surgery) _____.

Please turn page over

5. **Voluntary Act/Conditioning of Treatment:** I expressly acknowledge that this Authorization is voluntary. I do not have to sign this authorization in order for me (my child) to receive treatment from the Practice. In fact, I have the right to refuse to sign this authorization. I understand that treatment provided for research related purposes only or treatment provided solely to create PHI will not be provided if I do not sign this Authorization.

6. **Revocation:** I understand that this Authorization may be revoked by me at any time, provided that I submit a signed revocation form to the Practice's Privacy Officer. However, any revocation shall not apply to the extent that the Practice has taken action in reliance on this Authorization.

7. **Re-disclosure:** I understand that the information used or disclosed pursuant to this Authorization may be re-disclosed by the recipient, and that the information will no longer be protected by the Practice or the HIPAA Privacy Rules.

8. **Remuneration:** I understand that the Practice will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI other than a record copying and/or processing fee.

9. **Copy of Authorization:** If the Practice has requested this Authorization from me, I understand that the Practice will provide me with a copy of this Authorization once signed by me.

Would you like to be notified prior to your records being sent? Yes No

Name of Patient (Printed)

Patient's Address (number and street, city, state, zip)

Phone Number

Signature of Parent/Personal Representative

Relationship (e.g., Parent if a minor, Guardian, Attorney-In-Fact)

Date Signed ____/____/____

Witness: _____

(Revised 4/12)