PATIENT AUTHORIZATION

Copying Charges: $20 for 1st 40 pages & $.25 each add 1 page for personal use, transfer of care, insurance, and attorneys.

I hereby authorize employees or other agents of

_____

(Name of Practice)

to use or disclose the following health information about me:

_____

_____

for the following purposes:

_____ at the request or direction of the undersigned individual
_____ insurance policy change
_____ insurance application
_____ Other (describe): _____

_____

The health information described above may be used by or released to:

_____

_____

The Authorization expires:
_____ On the following date: ____/____/____ (normally 1 year from date of signed authorization).

_____ When the following events occur:

_____

_____

_____ _____ _____
(Patient's Signature*) Birthdate SS#

_____ _____ am/pm
(Witness) (Date) (Time)

*The above individual is unable to consent because (check one):

_____ Minor _____ Incompetent _____Other (Explain): _____

I therefore consent on behalf of the individual named above.

_____ _____
(Signature) (Relationship)

_____ _____ am/pm
(Witness) (Date) (Time)

AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this Authorization, you are permitting the use and/or disclosure of your health information for the limited purpose(s), and in the limited manner, described in this form. Except as authorized by this form, we are required by federal law to maintain the privacy of your health information as described in our Notice of Privacy Practices.

Refusals of Service

If the only reason you have asked us to provide a health care service is so that we can create information to be disclosed to a third party, we may refuse to provide the service if you refuse to sign this Authorization. For example, if you have requested a drug test solely for the purpose of having the results disclosed to your employer, we may refuse to perform the drug test if you refuse to sign this Authorization permitting us to disclose the results to your employer.

Otherwise, your ability to receive treatment, payment, enrollment in a plan, or eligibility for a benefit does not depend on your signing this form. **You may refuse to sign this form.**

Consequences of Signing this Form

Signing this Authorization may cause the health information used or disclosed pursuant to this Authorization to no longer receive the protections of federal privacy laws. Any person or Organization to whom your health information is disclosed pursuant to this Authorization might be able to legally re-disclose that information to others.

Revocation

You may revoke this Authorization at any time, in writing, except to the extent that we have already relied upon it in making a use or disclosure. Your written revocation will become effective when we have knowledge of it. If you are providing this Authorization to obtain insurance coverage, you may not have the right to revoke the Authorization to obtain insurance coverage, you may not have the right to revoke the Authorization to the extent that it pertains to the insurer's right under law to contest a claim under your insurance policy. If you wish to revoke this Authorization, please send your written request to:

Woman's Clinic, P.A.
Privacy Officer: Jon R. Ewing
244 Coatsland Drive
Jackson, TN 38301

Expiration

Once this Authorization has expired, we will no longer use or disclose your health information for the purpose listed in this Authorization unless you sign a new Authorization form.