

OBSTETRICS, GYNECOLOGY & MENOPAUSE PHYSICIANS, P.C.
Patient Authorization for Release of
Protected Health Information
for other than Research or Marketing Purposes

Patient name: _____ Date of Birth: _____

I hereby authorize [Person(s)/organization(s) being given authorization] _____

to use or disclose the following protected health information about me [Specific description of information (including date(s)) to be disclosed] _____

to [Person(s)/organization(s) receiving the information] _____

for the following purpose(s): _____

This Authorization shall expire _____

I understand that I have the right to revoke this authorization except to the extent that the practice has already released the information authorized by it. I understand that my revocation must be in writing and submitted to [name of the Practice]'s Privacy Officer at [address]. I understand that I do not have to sign this authorization in order to receive treatment from [name of Practice]. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be further disclosed by that organization.

Signature of patient or patient's representative _____ Date _____
(Form MUST be completed before signing)

Printed name of patient's representative: _____

Relationship to the patient: _____