Patient Authorization for Use and Disclosure of Protected Health Information

By signing this authorization, I _____authorize Modern Gynecology to use and/or disclose certain protected health information (PHI) about me to:
_____ (Name of entity to receive this information).

Relationship to the patient:_____.

This authorization permits Modern Gynecology to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as dates(s) of services, type of services, level of detail to be released, origin of information, etc.

The information will be used or disclosed for the following purposes:

If requested by the patient, purpose may be listed as “at the request of the individual.” The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on [date]: _____, or defined event.

The Practice will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from the Practice. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy and Security Officer at: 3851 Piper St – Suite U464, Anchorage, AK 99508.

Print Patient’s name or legal guardian: _____

Signed by: _____Date:_____