



Patient Authorization for Use and Disclosure of Protected Health Information

(This form lets Modern Gynecology talk with a loved one, **emergency contact**, friend, or other person you choose about your care if needed- including if they call on your behalf or if there is an urgent or emergency situation and we cannot reach you directly.)

By signing this authorization, I _____ authorize Modern Gynecology to use and/or disclose certain Protected Health Information (PHI) about me to:

Name: _____

Relationship to Patient: _____ Phone: _____

Information to be Disclosed (check or describe):

- | | |
|---|---|
| <input type="checkbox"/> ALL relevant medical information | <input type="checkbox"/> Billing/ insurance |
| <input type="checkbox"/> Test results | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Treatment plans | |

Authorization Applies To (check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Routine care discussions | <input type="checkbox"/> Billing questions |
| <input type="checkbox"/> Scheduling matters | <input type="checkbox"/> Emergency situations when I cannot be reached |
| <input type="checkbox"/> Test results/ treatment | <input type="checkbox"/> When the individual calls on my behalf |

Purpose and Scope of Disclosure:

This authorization allows Modern Gynecology to communicate with the individual listed above regarding my care, appointments, test results, billing matters, and treatment information. This includes situations where the listed individual contacts the practice on my behalf and urgent or emergency circumstances when I am unavailable or unable to communicate directly. By signing, I permit Modern Gynecology to speak with, share information with, and receive information from this individual regarding my medical care and related time-sensitive decisions.

Expiration: This authorization expires on _____ or upon this event: _____.

The Practice will not receive payment from a third party for using or disclosing this PHI. I am not required to sign this form to receive treatment. I may refuse to sign. Information disclosed under this authorization may be redisclosed and no longer protected by HIPAA. I may revoke this authorization in writing at any time except where action has already been taken in reliance on it. Revocation must be submitted to the Privacy Officer at 3851 Piper St – Suite U464, Anchorage, AK 99508.

Patient Name: _____

Signature: _____ **Date:** _____

If signed by legal representative, print name/relationship: _____

Signature: _____ **Date:** _____