

SWAN MOUNTAIN WOMEN'S CENTER, PC
Authorization to Use or Disclose My Health Information

Patient name: _____ Date of birth: _____

Previous name: _____

I. My Authorization

You may use or disclose the following health care information (check all that apply):

- All my health information maintained by the above-named practice
 My health information relating to the following treatment or condition: _____
 My health information for the date(s): _____

I specifically authorize disclosure of the following conditions (check all that apply):

- Drug abuse Alcohol abuse HIV/AIDS psychological or psychiatric conditions, including psychotherapy notes

You may disclose this health information to:

Name (or title) and organization _____

Address: _____ City _____ State _____ Zip _____

Reason(s) for this authorization (check all that apply):

- At my request
 Check here only when Swan Mountain Women's Center, PC requests the authorization for marketing purposes
 Check here only if this authorization involves the sale of protected health information
- Check here only when Swan Mountain Women's Center, PC will get anything of value for providing health information (other than copying costs)
 Other (specify) _____

This authorization ends: On (date) _____
 When the following event occurs _____

II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment or eligibility for benefits). However, I do have to sign an authorization form:

- To take part in a research study;
or
- To receive health care when the purpose is to create health information for a third party.

I may revoke this authorization in writing. If I revoke this authorization, it would not affect any actions already taken by the above-named practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- Fill out a revocation form. The form is available from the office;
or
- Write a letter to the office.

Once the office discloses health information, the person or organization that receives it may be able to redisclose it. Privacy laws may no longer protect it.

Patient or legally authorized individual signature Date Time

Printed Name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative, etc.)