AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient's Name:	**Birth Date:**	**Social Security Number:**

Provider's Name:	**Recipient's Name:** **Advanced Women's OBGYN Associates** ☐ **PLEASE FAX 561-795-6813**
Provider's Address:	**Address 1:** **12953 Palms West Dr., Suite 101**

City:	**State:**	**Zip:**
Loxahatchee	**FL**	**33470**

Expiration Date or Event: This authorization will expire on the following expiration date (or) expiration event:
Date: **Event:**

Purpose of Disclosure:

Description of Information to be Used or Disclosed

Is this request for psychotherapy notes?
☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below.
☐ No, then you may check as many items below as you need.

Description:	**Date of Service:**	**Description:**	**Date of Service:**	**Description:**	**Date of Service:**
☐ **All PHI in Medical Record**	Start date: End date:	☐ Operative Information		☐ Labor/Delivery Notes	
		☐ Special Test/Therapy		☐ Postpartum Notes	
☐ Admission Form		☐ Nursing Information		☐ ER Information	
☐ Physician Orders		☐ Transfer Forms		☐ Other:	

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary. However, refusal to sign will render this form invalid.
2. I understand that protected health information may include information and records protected under Federal and State Law such as; alcohol, drug abuse, mental health, AIDS or HIV testing or treatment.
3. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
4. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
5. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
6. There may be a reasonable fee to obtain a copy the information being requested on this form.
7. I get a copy of this form after I sign it.

Section B: Is the request of PHI for the purpose of marketing?
If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? ☐ Yes ☐ No
If yes, describe:

Section C: Required Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Guardian/ or Personal Representative:	**Date Signed:**

Printed Name of Patient/Guardian/ or Personal Representative:	**Relationship of Personal Representative to Patient:**