AUTHORIZATION FOR THE USE AND DISCLOSURE OF MEDICAL INFORMATION

I, _____, hereby authorize Women's Health Associates of Southern Nevada, PLLC to use and/or disclose a copy of my medical records containing individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that this disclosure may include HIV-related, mental health, or substance abuse information. I also understand that, if the organization authorized to receive the information is not a health care provider or health plan, the released information may no longer be protected by state or Federal privacy laws or this authorization.

Person/Organization Providing the Information:

_____

Name of Patient or Representative:

_____

Person/Organization Authorized to Receive the Information:

_____

Specific and meaningful description of the information to be used and/or disclosed (such as dates of service or treatment, type of service or treatment, level of detail to be released or origin of information):

_____

_____

_____

_____

This medical information is being used and/or disclosed for the following purpose(s):
("At the Request of the Individual" is sufficient if the request is made by the patient and the patient does not want to state a specific purpose.)

_____

_____

_____

This Authorization shall remain valid and in effect until:

A) (MM/DD/YR): _____/_____/_____ OR

B) The event that relates to the use and/or disclosure occurs and this Authorization is no longer necessary. This expiration event is:

_____

_____

_____

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to the Privacy Officer. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I also understand that my physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except (1) if my treatment is released to research or (2) if health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

_____
Patient Name

_____ _____/_____/_____
Patient/Health Care Agent/Guardian/Relative Signature Date

_____
Description of Personal Representative's Authority

A SIGNED COPY OF THIS AUTHORIZATION MUST BE GIVEN TO THE PATIENT.