Physicians & Surgeons for Women

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INSURANCE

By signing this form, I authorize:

PHYSICIANS & SURGEONS FOR WOMEN, INC.
1821 E. High Street
Springfield, OH 45505
and
900 Scioto St., Suite 6
Urbana, OH 43078
Phone (937) 323-7340 Fax (937) 323-3363

1) To use and/or disclose certain protected health information (PHI) about me to:
Name of Physician, Facility or other: _____
Mailing Address: _____
City _____ State _____ Zip _____
Phone _____ Fax _____

For the purpose of:
_____ Continuity of care (i.e. to specialist or family doctor)
_____ Transfer of care to another physician
_____ Insurance reasons
_____ Attorney/Court case
_____ Onsite review of my medical file by: _____
_____ HEDIS report for Insurance
_____ Personal reasons
_____ Other : (Please specify) _____

2) The type and amount of information to be used or disclosed is as follows (check appropriate lines)

_____ Office notes	Date: _____	thru _____
_____ Lab results	Date: _____	thru _____
_____ Pap results, cultures, Pathology	Date: _____	thru _____
_____ Hospital records and notes	Date: _____	thru _____
_____ Mammogram and other X-ray	Date: _____	thru _____
_____ Entire medical record with no exclusions		
_____ Entire medical records for	Date: _____	thru _____
_____ Other : (Please specify)	Date: _____	thru _____

3) I understand that the information in my health record may include information relating to sexually transmitted disease, AIDS< or HIV. It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

4) I understand I have the right to revoke this authorization at any time. I **understand if I revoke this authorization, I must do so in writing and present my written revocation to the Privacy Officer of the facility listed in item #1 above.** I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurance with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire one year from the signature date.

5) I understand that I do not have to sign this form in order to receive treatment from Physicians & Surgeons for Women, Inc. 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 re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy rule.

6) By transferring care, I understand that I have the right for Emergent Care only for 30 days from the date of this consent. I understand that I will no longer be scheduled for appointments unless emergent and then only when and if approved by my Physician.

Patient Name: _____ D.O.B. _____

Signature of Patient or Legal Guardian: _____ Date: _____

If signed by Legal Representative, Relationship to Patient: _____