

WOMEN FIRST OF LOUISVILLE, PLLC
3900 Kresge Way, Ste. 30
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Authorization for Use of Protected Health Information

Patient Name _____ Date of Birth _____

I authorize _____ to disclose my medical records to

(name and address of recipient)

This protected health information is being used or disclosed for the following purposes (**Please check all boxes that apply**):

- | | |
|---|--|
| <input type="checkbox"/> Referred to another MD | <input type="checkbox"/> Moving |
| <input type="checkbox"/> Insurance change | <input type="checkbox"/> Personal reason _____ |
| <input type="checkbox"/> Transfer to new practice – can you share the reason for transferring? _____ | |
| <input type="checkbox"/> Other _____ | |

By checking the spaces below, I specifically authorize the use and/or disclosure of the following health information, if such information or record exists:

- | | |
|---|------------------------------------|
| _____ Please send the entire medical record to the above named recipient. | |
| _____ All hospital records | _____ Clinician office chart notes |
| _____ Transcribed hospital reports | _____ Laboratory reports |
| _____ Pathology reports | _____ Diagnostic imaging reports |
| _____ Emergency and urgent care records | _____ Consultation |
| _____ Other _____ | |

I understand that this may include health information relating to HIV/AIDS, treatment for alcohol and/or drug abuse, mental health and genetic testing.

I understand that if the person(s) or entity(ies) that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and is no longer protected by those regulations. Therefore I release Women First of Louisville, PLLC, its employees, and physicians from all liability arising from this disclosure of my health information.

I understand that I may inspect or request copies of any information disclosed by this authorization. It is my understanding that this authorization will expire in 180 days from the date signed below. I understand that I may revoke this authorization by notifying, in writing, the Medical Records Department, knowing that previously disclosed information would not be subject to my revoke request.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or my eligibility for benefits.

Signature of Patient or Legal Representative

Date

Relationship of Representative to Patient

Signature of Witness

Date