

**WOMEN FIRST OF LOUISVILLE, PLLC  
AUTHORIZATION FOR USE OF  
PROTECTED HEALTH INFORMATION**



Patient Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_

I authorize Women First of Louisville, PLLC, to disclose my medical records to:

\_\_\_\_\_  
(Name and address of recipient)

This protected health information is being used or disclosed for the following purposes: \_\_\_\_\_

By initialing 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 will include health information relating to (please initial)

- |       |  |       |                 |
|-------|--|-------|-----------------|
| _____ | HIV/AIDS                                 | _____ | Mental Health   |
| _____ | Treatment for alcohol and /or drug abuse | _____ | 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 any 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