

Authorization for Disclosure of Health Information-To PWC

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

Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

- 1. I authorize the use or disclosure of the above named individuals health information as described below:
- 2. The following individual, medical group, or organization is authorized to make the disclosure:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

- 3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate).  
 Complete Health Records (limited to two years)     Lab results/Ultrasound reports  
 Office chart notes     Consultation reports  
 Hospital records     Entire medical records  
 Genetic Testing

Other (please specify): \_\_\_\_\_

- 4. I understand that the information in my health record may include information relating to sexually transmitted disease, genetic testing, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.
- 5. This information may be disclosed to and used by the following individual, medical group, or organization:

Name: **Pacific Women's Center, LLC** \_\_\_\_\_ Phone: **541-342-8616** \_\_\_\_\_ Fax: **541-686-4814** \_\_\_\_\_

Address: **10 Coburg Rd., Suite 100** \_\_\_\_\_

City: **Eugene** \_\_\_\_\_ State: **OR** \_\_\_\_\_ Zip: **97401** \_\_\_\_\_

For the purpose of: \_\_\_\_\_

- 6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: \_\_\_\_\_
- 7. If I fail to specify an expiration date, event, or condition; this authorization will expire in 180 days. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not to sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information I can contact: Dawn Crump- Privacy Officer for: Pacific Women's Center, LLC.

\_\_\_\_\_  
Signature of patient or legal representative

\_\_\_\_\_  
Signature of witness

Date: \_\_\_\_\_

Date: \_\_\_\_\_

PLEASE NOTE: This information has been disclosed to you from confidential records protected by disclosure by state and federal law. No further disclosure of this information should be done without specific written and informed release of the individual to whom it pertains or as permitted by state law (ORC-3701.243) and federal law (42 CFR, part II).