

**Professionals for Women's Health**

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**AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

Patient's Name \_\_\_\_\_ Phone# \_\_\_\_\_ P  
Patient's Address \_\_\_\_\_  
Patient's Date of Birth \_\_\_\_\_ Last 4 digits of SSN \_\_\_\_\_

**I hereby authorize the USE & DISCLOSURE of my medical records:**

Person/Organization Authorized to **RELEASE** Information:  
Information:

Name \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Ph# \_\_\_\_\_ Fax# \_\_\_\_\_

Person/Organization Authorized to **RECEIVE**

Name \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Ph# \_\_\_\_\_ Fax# \_\_\_\_\_

**For the following protected health information:**

\_\_\_\_\_ Entire Chart

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

HIV, Behavioral Health, or Drug and Alcohol Abuse/Treatment information contained within the dates of service I have specified above are to be released through this authorization unless specified below:

DO NOT RELEASE: (Check all that apply)  HIV  Behavioral Health  Drug/Alcohol

I am requesting my records to be disclosed for the following purpose:

\_\_\_\_\_

This authorization expires ninety (90) days from signature, or at the following event: \_\_\_\_\_

I may revoke this authorization at any time by mailing or personally delivering a signed, written notice of revocation to the healthcare provider at which this authorization was executed. Such revocation will be effective upon receipt, except to the extent that the recipient has already taken action in reliance on this authorization. I am entitled to a copy of this authorization upon my request. I may not be required to sign this authorization as a condition to obtaining treatment or payment or my eligibility for benefits. The recipient of this protected health information is prohibited from re-disclosing the information unless the recipient obtains another authorization for me or unless the disclosure is specifically required or permitted by law. Where permitted, the information I am requesting to be disclosed may sometimes be re-disclosed by the recipient and may no longer be protected by law. I am entitled to notice if my protected health information is used for marketing and results in remuneration to the provider. I hereby acknowledge that I have read and fully understand the above statements as they apply to me.

Patient Signature:

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

Signature of Parent/Guardian or Personal Representative:

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

There is a per page fee, payable prior to release of records.