All portions of this form *must* be completed to constitute a valid authorization for release of health information under the Health Insurance Portability and Accountability Act (HIPAA) privacy regulations. If any field is left blank, the authorization will be considered defective.

| Patient's Name: | Date of Birth: | SSN: |
|---|---|---|
| Address: | Medical Record Number: | Telephone Number: |

I authorize the use and disclosure of health information about me as described below: **

Facility Authorized to Release my Health Information:

Agency or Individual(s) Authorized to Receive my Health Information:

**All Seasons OB/GYN Phone 435-843-2576 Fax 435-843-3575**

Health Information that may be used/disclosed is limited to the following:

| | | | |
|---|---|---|---|
| Discharge Summary | Consultation(s) | Pathology Report | LAB |
| History & Physical | Operative Note(s) | Imaging / X-Ray | Entire Record |

Other: (Specify)_____

Health Information that may be used/disclosed is limited to the following Treatment Dates:

Health information to be released to the above named agency/ individual is to be used/ disclosed for the following purpose(s) (include Research or Marketing, if appropriate):

## Continued Care

Health information identifies you (the patient) by name, and includes other demographic information about you. Health information may include, but is not limited to: medical records, x-ray films, slides, tracings, strips, etc. I hereby discharge the releasing facility, its agents and employees from any and all liabilities, responsibilities, damages, and claims which might arise from the release of information authorized herein, to include alcohol, drug abuse, communicable disease including HIV status, and/or psychiatric diagnoses compiled during my visit, encounter or hospitalization, or make copies thereof in accordance with the policies of this facility. Protected Health Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by this privacy rule. If research-related Health Information is used or disclosed for continued research purposes, and expiration date or event does not apply. This authorization will automatically *expire 60 days* after the date below (except as indicated above), unless an earlier date is specified, or at the conclusion of a specified event. I understand that I have a right to revoke this authorization at any time, in writing, as stated in the Notice of Privacy Practices, except where the facility has already made disclosures in reliance upon my prior authorization. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on obtaining an authorization if the Health Information Portability Accountability Act prohibits such conditioning. If conditioning is permitted, refusal to sign the authorization may result in denial of care or coverage.

**NOTICE TO RECEIVING AGENCY OR INDIVIDUAL: This information is to be treated in accordance with Health Insurance Portability and Accountability Act (HIPAA) privacy regulations.**

| Patient's or Authorized Personal Representative's Signature: | Date: | Time: |
|---|---|---|
| Relationship to Patient! Authority to Act on Patient's Behalf: | Interpreter, if utilized: | |
| Witness Signature: | Expiration Date or Event: | |

** There may be a charge for copying Medial Records.