Westside OB-GYN Center

INDIVIDUAL AUTHORIZATION

Patient Name: _____ **DOB** _____

We understand that information about you and your health is personal, and we are committed to protecting the privacy of that information. Because of this commitment, we must obtain your written authorization before we may use or disclose your protected health information for the purposes described below. This form provides that authorization and helps us make sure that you are properly informed of how this information will be used or disclosed. Please read the information below carefully before signing this form.

USE AND DISCLOSURE COVERED BY THIS AUTHORIZATION

Who will use and/or receive the information? Please check those that apply and write out individual(s) name.

- ☐ Husband: _____
- ☐ Mother/Father: _____
- ☐ Sibling: _____
- ☐ Child(ren): _____
- ☐ Other: _____

What information will be used or disclosed? Please check those that apply.

- ☐ Appointments dates and times, _____
- ☐ Diagnostic test results, _____
- ☐ Laboratory results, _____
- ☐ Office visit/procedure notes, _____
- ☐ Hospital inpatient/procedure notes, _____
- ☐ HIV, Substance Abuse, Psychiatric/Psychotherapy Care, Sexually Transmitted Disease
- ☐ Other, _____

When will this authorization expire? _____

SPECIFIC UNDERSTANDING

By signing this authorization form, you authorize the use or disclosure of your protected health information as described above. This information may be redisclosed if the recipient(s) described on this form is not required by law to protect the privacy of the information, and such information is no longer protected by federal health information privacy regulations.

If you are authorizing the release of HIV-related information, you should be aware that the recipient(s) is prohibited from redisclosing any HIV-related information without your authorization unless permitted to do so under federal or state law. You also have a right to request a list of people who may receive or use your HIV-related information without authorization.

You have a right to refuse to sign this authorization. Your health care, the payment for your health care, and your health care benefits will not be affected if you do not sign this form, but we will not be permitted to use or disclose your information as described on this form without your signature.

You have a right to receive a copy of this form after you have signed it.

If you sign this authorization, you will have the right to revoke it at any time, expect to the extent that Westside Ob/Gyn has already taken action based upon your authorization. To revoke this authorization, please write to Westside Ob/Gyn.

SIGNATURE

I have read this form and all of my questions about this form have been answered. By signing below, I acknowledge that I have read and accept all of the above.

_____ _____

Patient Name **Date**