AUTHORIZATION

For the Use and Disclosure of Protected Health Information

The Health Insurance Portability and Accountability Act of 1996 states that we cannot share your protected health information without your permission, except in certain situations. For example, your protected health information can be shared without your permission if it is used to facilitate your health care treatment, payment, or for health plan operations. If you sign this form, you are giving us permission to share the protected health information you indicate below. This does not protect the information from being shared with more people once it leaves our office.

This authorization will only last until the date you specify, and must expire on a specific date or upon the occurrence of a specific event.

If you decide later that you do not want us to share your protected health information any more, you may cancel your authorization at any time by signing the REVOCATION SECTION at the end of this form

Date: _____

Person or group authorized to receive and use my protected health information:

_____

I, _____ (print your name) **authorize Four Corners OB/GYN to share the protected health information checked below with the person or group listed above:**

- ❑ Information related to medical care for the following time period (specify dates):

  From: _____ To: _____

- ❑ Other (specify): _____

  From: _____ To: _____

Purpose of request for information: (If you prefer not to state a purpose, please state "At the request of the individual")

_____

Expiration of authorization: (You must specify a date or event, i.e., at the end of litigation)

Date / event of expiration: _____

Signature: _____ Date: _____

Date of birth: _____

REVOCATION SECTION

I understand that I have the right to revoke this authorization at any time by notifying the Privacy Officer of the practice. I understand that the revocation is only effective after it is received and logged by the Department's Privacy Officer. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation.

I no longer want my protected health information used or disclosed to the person listed above.

Signature: _____ Date: _____