



# University Women's HealthCare

## AUTHORIZATION FORM FOR THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

### University Women's HealthCare

Main Office

401 E. Chestnut St  
Suites 410, 470, 40202

(502) 271-5999

Continence Center

401 E. Chestnut Street  
Suite 460, 40202  
(502) 271-5066

Brown Cancer Center

529 S. Jackson St 3rd Fl, 40202  
(502) 561-7220

### University Women's HealthCare

550 S. Jackson St  
 3rd Fl OB/GYN Clinic, 40202  
(502) 561-8850

3rd Fl Ultrasound Department, 40202  
(502) 561-8838

This authorization, if signed, will authorize University Women's HealthCare to use and/or disclose certain protected health information that is in the practice's possession about the person named below.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I hereby authorize the use and/or disclosure of my protected health information as described below:

|   | Date(s) of service |
|---|--------------------|
| <input type="checkbox"/> All                                | _____              |
| <input type="checkbox"/> History & Physical Examination     | _____              |
| <input type="checkbox"/> Progress Note                      | _____              |
| <input type="checkbox"/> Test Results                       | _____              |
| <input type="checkbox"/> Consultation Reports               | _____              |
| <input type="checkbox"/> Operative Report                   | _____              |
| <input type="checkbox"/> Photos, videotapes or other images | _____              |
| <input type="checkbox"/> Other (please list)                | _____              |
| <input type="checkbox"/> Ultrasound                         | _____              |

\_\_\_\_\_  
\_\_\_\_\_

1. My authorization applies to the information described below. Only this information may be used and/or disclosed pursuant to this authorization:
2. I understand that this information may include information relating to Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) infection, treatment for drug or alcohol abuse, or mental or behavioral health or psychiatric care.



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3. The authorized person (or entity) to request and receive the information indicated in this authorization

is:

Name (or Entity) \_\_\_\_\_.

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

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

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

4. The protected health information being used and/or disclosed under this authorization is for the

following purpose (you may leave this blank if you are the patient or the patient's legal guardian and

the protected health information is being released to you.)

5. I understand that if my protected health information is disclosed to someone who is not required to

comply with the federal privacy regulations, then such information may be re-disclosed and would no

longer be protected.

6. I understand that I have the right to revoke this authorization, in writing, at any time by sending such

written notification to University Women's HealthCare (please specify practice site). I also understand that my request is not effective for actions already completed.

7. Unless otherwise revoked, I understand that this authorization will expire one hundred and eighty

days (180) from the date of this form or on the following date or event:

\_\_\_\_\_

8. I understand that I do not have to sign this authorization as a condition of being treated by University

Women's HealthCare

I certify that I have received a copy of this authorization.

\_\_\_\_\_  
Signature (Patient or Patient's Representative)

\_\_\_\_\_  
Date



# University Women's HealthCare

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Printed name of Patient's representative given authority to act for patient

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Relationship to Patient