

Account # _____

ASHLEY WOMEN'S CENTER, P.A.
Authorization for Disclosure of Health Information

I hereby authorize the use or disclosure of named individual's health information as described below:

Patient Name: _____ Date of Birth: _____

Daytime Phone Number: _____ SSN: _____

Name and address of Covered Entity authorized to make the disclosure:

This information may be disclosed to and used by the following individual or organization:

The following information is authorized for use & disclosure: **Reason for use & disclosure (REQUIRED):**

- | | |
|--|-----------------------------|
| <input type="checkbox"/> Office visit notes | _____ Continuing Care |
| <input type="checkbox"/> Lab test results | _____ Transfer of Care |
| <input type="checkbox"/> Imaging test results | _____ Insurance |
| <input type="checkbox"/> Summaries of procedures, operations, hospitalizations | _____ Personal reasons |
| <input type="checkbox"/> Complete record | _____ Attorney/Court Case |
| <input type="checkbox"/> Other (please specify) _____ | _____ Other (specify) _____ |

Covering the date(s) of healthcare from _____ to _____.

Patient Rights:

I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse

I understand that any disclosure of information carries with it the potential for redisclosure and that the information then may not be protected by federal confidentiality rules.

I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing. And I understand that the revocation will not apply to information already released based on this authorization.

I understand that I have a right to inspect and receive a copy of the information that is used or disclosed based on this authorization.

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event, or condition: (If you do not specify an expiration date, event, or condition, this authorization will expire in six (6) months.) _____

Signature of Patient or Representative

Date

Printed Name of Representative (if applicable)

Relationship to Patient

Witnessed By

| | | | |
|------|---------------------|--------------------|---------|
| Fees | \$10.00 pages 1-13 | Pages 1-13 = | \$10.00 |
| | + 0.75 pages 14-25 | # of pages x .75 = | _____ |
| | + 0.50 pages 26-100 | # of pages x .50 = | _____ |
| | + 0.25 pages 100+ | # of pages x .25 = | _____ |
| | | TOTAL FEE = | _____ |

Title and Date

Ashley Women's Center, P.A.
1225 E. Garrison Blvd. Gastonia, NC 28054
1212 Spruce Street, Ste. 307 Belmont, NC 28012
Phone 704-865-7416
Fax 704-865-7232

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+ 0.25 pages 100+ # of pages x .25 = ____
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