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Center for Gynecologic Oncology

Authorization to Disclose Health Information

Patient Name: _____ **Acct Number: _____**

Date Of Birth: _____

With my signature below, I authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization and/or person authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Persons/Organizations providing the information:	**Persons/Organizations receiving the information:** ● If person: name,date of birth and relationship to patient. ● If organization/provider: Name, Address, and phone number and fax number
Specific description of information provided (i.e.,exam notes, test results, billing information, speak to provider about care plan, etc.) **and dates or date ranges**	**Purpose of requested Use or Disclosure**

The patient or patient's representative must read and **initial** the following statements:

_____ 1. I understand that this authorization will expire on ____/_____/_____ **(DD/MM/YEAR)**. If I fail to specify a date, the authorization will expire in six (6) months from the date signed.

_____ 2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing. I understand that the revocation will not apply to information which has already been released in response to this authorization and will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

_____ 3. I understand that my health care and the payment for my healthcare will not be affected if I do not sign this form.

_____ 4. I understand that I may see and copy the information described on the form and will receive a copy of this form after it is signed.

_____ 5. If I have questions about disclosure of my health information, I can contact the office staff or the physician.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
If signed by Legal Representative, Relationship to Patient Signature of Witness