Warner Robins OB-GYN, LLC

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Information about the Patient:

Patient Name: _____ DOB: _____/____/_____
Last First Middle

Address: _____ Phone: _____

The Patient identified above hereby authorizes Warner-Robins OB-GYN, LLC ("Practice") to release and disclose Patient's Protected Health Information, as defined by HIPAA ("PHI") to the following person or organization ("Recipient"):

Name of Recipient of PHI: _____

Address: _____ Phone: _____

This Authorization applies to the following PHI:

☐ All Records pertaining to: _____

☐ Other: _____

☐ This Authorization applies only to the following dates of service: ____/____/____, ____/____/____, ____/_____/____.

☐ This Authorization applies only to the dates of service during the period of time: From: ____/____/____ To: ____/____/____.

The disclosure of PHI <u>will not</u> include the following information <u>unless</u> the appropriate box is checked:

☐ Any records of treatment for drug and/or alcohol dependency or abuse.

☐ Any record of mental health treatment, psychological services, social services, including communications made to a social worker or psychologist.

☐ Any record of testing, care, treatment or research pertaining to HIV, AIDS or other communicable diseases.

Please provide PHI to Recipient in the following manner (please select one; if none selected, PHI will be provided in hard copy by mail):

_____ Mailed copy _____ Faxed Copy _____ Electronic copy _____ Other (describe on a separate sheet)

Electronic Format Requested: _____

Information about the person or organization <u>Authorizing</u> the Disclosure of PHI, *if Other Than the Patient Listed Above*:

Name: _____

Relationship to Patient: _____ ☐ Documents of Relationship to Patient Attached

Address: _____ Phone: _____

I understand that (i) authorizing the disclosure of PHI to the Recipient is voluntary, (ii) this Authorization covers multiple requests for and disclosures of PHI and authorizes the Practice to make such disclosures, (iii) I may refuse to provide authorization for disclosure of PHI to the Recipient, and Practice may not condition treatment, payment for services, or eligibility for benefits on whether I sign this Authorization, (iv) any disclosure of PHI carries with it the potential for an unauthorized re-disclosure by the Recipient and the information may not be protected by federal or state privacy rules, and (v) the Practice must provide a copy of this signed Authorization to me.

This Authorization may be revoked at any time in writing by providing a signed revocation to Practice at 225 Smithville Church Rd, Suite 1100, Warner Robins, GA 31088. The revocation is effective upon receipt but will have no impact on uses or disclosures of PHI made while the Authorization was valid. If not previously revoked, this Authorization shall expire one (1) year from the date of the Patient's last visit to Practice. For additional information on uses and disclosures of PHI by Practice please refer to our Notice of Privacy Practices.

I ACKNOWLEDGE AND AGREE THAT IF I REFUSE TO PROVIDE THIS AUTHORIZATION OR REVOKE THIS AUTHORIZATION PRIOR TO PRACTICE'S DISCLOSURE OF THE PHI, Practice IS NOT RESPONSIBLE FOR ANY CONSEQUENCES OF FAILURE TO DISCLOSE ANY INFORMATION TO THE RECIPIENT AND IS NOT RESPONSIBLE TO NOTIFY ME OR ANY THIRD PARTY OF ANY SUCH CONSEQUENCES. I AGREE THAT I WILL NOT HOLD Practice AND/OR ITS AGENTS RESPONSIBLE FOR ANY LIABILITY, LOSS, DAMAGE OR EXPENSE CAUSED OR INCURRED AS A RESULT OF MY REFUSAL TO PROVIDE THIS AUTHORIZATION, REVOKING THIS AUTHORIZATION, AND/OR IN CONNECTION WITH ANY DISCLOSURE OF PHI PURSUANT TO THIS AUTHORIZATION.

Patient's Signature: _____ Date: ___/___/_____

Patient's Authorized Representative's Signature: _____ Date: ___/___/_____

For Office Use Only:

If Patient is unable to sign, secure signature of Next of Kin or Legal Agent/Guardian and indicate reason why Patient is unable to sign:

☐ Minor ☐ Disoriented

☐ Incompetent ☐ Medically Unstable

Processor's Initial's _____ Date Sent Out: ____/____/___