SAN FRANCISCO
PERINATAL ASSOCIATES, INC

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Authorization to Use or Disclose Health Information

Patient Name		Daytime phone #
Date of Birth	SS#	Medical Record #

1. I hereby authorize the use and disclosure of the above named patient's protected health information as described below.

2. The following individual(s) or organization(s) are authorized to make the requested disclosure:

3. The type of protected health information to be used or disclosed is as follows: (check the appropriate box)

Dates of Service:

	Entire Record		Other (Please specify):

4. I understand that if my authorization includes Behavioral Health, substance abuse or HIV information, it may include; (i) information concerning whether an individual has been the subject of an human immunodeficiency virus (HIV) – related test, has HIV, an HIV related illness, acquired immunodeficiency syndrome (AIDS), and/or including information pertaining to the individual's contact (Section 7100.133); (ii) progress and/or short statement as to whether I have relapsed into substance abuse and the frequency of such release (Pennsylvania Drug and alcohol abuse control act of 1972 – act 148 section 7(e); (iii) behavioral health information services. (Mental Health Procedures Act 1976, section 5100.3-39).

5. The protected health information identified above may be disclosed to or used by the following individual(s) or organization(s):

Name	Address Fax

6. This protected health information for which I'm authorizing disclosure will be used for the following purpose:

	Sharing with other health care provider as needed		Other (please describe)

7. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the medical record department. I understand that the revocation will be effective upon receipt, but will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

8. I authorize San Francisco Perinatal Associates to send me communications which may include protected health information to the following fax number_____ which is secure and which only I have access to.

8. Unless I specify differently, **this authorization will expire six months from the date signed below**.

9. I understand that once the above information is disclosed, it may be re-disclosed by the patient and the information may not be protected by federal privacy laws or regulations.

10. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

_____ _____ _____
Signature of patient or legal representative **Printed Name** **Date**

If signed by legal representative, relationship to patient _____

_____ _____ _____
Signature of witness **Printed Name** **Date**

Revised 08/2012 *A copy of this authorization form has been included with the copy of the medical record.*