AUTHORIZATION TO RECEIVE HEALTH INFORMATION

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ACCENT ON WOMEN'S HEALTH
2460 NW Stewart Parkway, Suite 240 ● Roseburg, OR ● 97471 ● Phone: 541-677-4427 ● Fax: 541-677-6522

I authorize _____to use and disclose a copy of the health information described below regarding me, _____, to Accent on Women's Health for the purpose of (check one) ☐ Transfer of Care -or- ☐ Continuity of care. The health information to be used and disclosed includes the information specifically authorized below as well as all other information in my health records relevant to the above-described purpose.

Health Information to be released (Initial **ONE** of the boxes below**):**

☐ Complete Health Record/All dates

-OR-

☐ Specific Records: _____

Dates: from _____to_____

____ By initialing here, I specifically consent to the disclosure of my HIV/AIDS/STD information.

____ By initialing here, I specifically consent to the disclosure of my mental health information.

____ By initialing here, I specifically consent to the disclosure of my genetic testing information.

____ By initialing here, I specifically consent to the disclosure of my drug and alcohol diagnosis, treatment, or referral information, which requires under federal law a description of how much and what kind of information is to be disclosed.

I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law. Unless revoked earlier, this Authorization shall remain in effect until my death.

Dated _____, 20_____ Patient Phone: _____

_____ Date of Birth: _____/_____/_____
(Print patient name)

_____ _____
(Signature of patient or legal guardian) (Print guardian name)

If we, the healthcare provider, are requesting this Authorization from you for our own use and disclosure or to allow another healthcare provider or health plan to disclose information to us:

1. We cannot condition our provision of services or treatment to you on the receipt of this signed authorization;.
2. You may inspect a copy of the protected health information to be used or disclosed;
3. You may refuse to sign this Authorization; and
4. We must provide you with a copy of the signed Authorization.

You have the right to revoke this Authorization at any time, provided that you do so in writing, and except to the extent that we have already used or disclosed the information in reliance on this Authorization or to the extent you signed this Authorization as a condition to insurance coverage. To revoke this Authorization, please contact our Privacy Officer.