FOXHALL
OB/GYN ASSOCIATES

Account No. _____

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: _____

SSN: _____

The following individual or organization is authorized to make the disclosure:

- ❑ Foxhall Ob/Gyn Associates, PC
- ❑ Other (please specify) _____

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

- ❑ Foxhall Ob/Gyn Associates, PC
- ❑ Other (please specify) _____

The following information is authorized for use & disclosure:

- ❑ Office visit notes ___ Continuing Care ❑ Lab test results
- ❑ Imaging test results
- ❑ Summaries of procedures, operations, hospitalizations
- ❑ Complete record (Last 5 years of care)
- ❑ Other (please specify) _____

Reason for use & disclosure:

___ Transfer of Care
___ Insurance
___ Personal reasons
___ Attorney/Court Case
___ Other (specify) _____

Sensitive Information: 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. _____ (Initials)

Redisclosure: 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. _____ (Initials)

Right to Revoke: 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._____ (Initials)

Right to Inspect and Copy: 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. _____ (Initials)

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 one year)

_____

_____ _____

Signature of Patient or Representative Date

_____

Patient's Name (printed)

_____ _____

Printed Name of Representative (if applicable) Relationship to Patient

A copy of this authorization will be provided to the patient.