WOMEN FIRST OF LOUISVILLE, PLLC

3900 Kresge Way, Ste. 30
Louisville, Kentucky 40207
(502) 891-8700 Fax (502) 891-8752

Authorization for Use of Protected Health Information

Patient Name _____ Date of Birth _____

I authorize _____ to disclose my medical records to

_____
(name and address of recipient)

This protected health information is being used or disclosed for the following purposes (**Please check all boxes that apply):**

☐ Referred to another MD
☐ Moving
☐ Insurance change
☐ Personal reason _____
☐ Transfer to new practice – can you share the reason for transferring? _____
☐ Other _____

By checking the spaces below, I specifically authorize the use and/or disclosure of the following health information, if such information or record exists:

_____ Please send the entire medical record to the above named recipient.
_____ All hospital records
_____ Clinician office chart notes
_____ Transcribed hospital reports
_____ Laboratory reports
_____ Pathology reports
_____ Diagnostic imaging reports
_____ Emergency and urgent care records
_____ Consultation
_____ Other _____

I understand that this may include health information relating to HIV/AIDS, treatment for alcohol and/or drug abuse, mental health and genetic testing.

I understand that if the person(s) or entitiy(ies) that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and is no longer protected by those regulations. Therefore I release Women First of Louisville, PLLC, its employees, and physicians from all liability arising from this disclosure of my health information.

I understand that I may inspect or request copies of any information disclosed by this authorization. It is my understanding that this authorization will expire in 180 days from the date signed below. I understand that I may revoke this authorization by notifying, in writing, the Medical Records Department, knowing that previously disclosed information would not be subject to my revoke request.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or my eligibility for benefits.

_____ _____
Signature of Patient or Legal Representative Date

_____
Relationship of Representative to Patient

_____ _____
Signature of Witness Date