WOMEN FIRST OF LOUISVILLE, PLLC
AUTHORIZATION FOR USE OF PROTECTED HEALTH INFORMATION

Patient Name ____

Date of Birth ____________________ Social Security # ____________________

I authorize ______________________________ to disclose my medical records, including my mammogram films to **Women First of Louisville, PLLC**.

This protected health information is being used or disclosed for the following purposes: ____________

____

By initialing 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

______ Transcribed hospital reports

______ Pathology reports

______ Emergency and urgent care records

______ Clinician office chart notes

______ Laboratory reports

______ Diagnostic imaging reports

______ Consultation

Other ____

I understand that this will include health information relating to (please initial)

______ HIV/AIDS

______ Treatment for alcohol and /or drug abuse

______ Mental Health

______ Genetic Testing

I understand that if the person(s) or entity(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 any 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

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