

**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
- Insurance change
- Transfer to new practice – **can you share the reason for transferring?** \_\_\_\_\_
- Other \_\_\_\_\_
- Moving
- Personal reason \_\_\_\_\_

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
- \_\_\_\_\_ Transcribed hospital reports
- \_\_\_\_\_ Pathology reports
- \_\_\_\_\_ Emergency and urgent care records
- \_\_\_\_\_ Other \_\_\_\_\_
- \_\_\_\_\_ Clinician office chart notes
- \_\_\_\_\_ Laboratory reports
- \_\_\_\_\_ Diagnostic imaging reports
- \_\_\_\_\_ Consultation

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 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 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