Mid Atlantic Women's Care, PLC
Authorization to use or disclose protected health information

I hereby authorize use or disclosure of the named individual's health information as described below:

Patient Name	Date of Birth	Social Security Number

Address (street, city, state, zip)	Telephone Number

Physician/person/agency and address authorized to release records:

_____
_____ Phone No. _____
_____ Fax No. _____

Physician/person/agency and address authorized to receive records:

_____
_____ Phone No. _____
_____ Fax No. _____

Treatment dates:	Purpose of request: ❑ Patient Request ❑ Other

The following information is to be disclosed: *(Please check box for each item)*

Yes	No	
❑	❑	Physician notes
❑	❑	Lab results
❑	❑	X-ray report
❑	❑	OB records
❑	❑	Financial records
❑	❑	Complete medical records
❑	❑	Other

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 the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

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.

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. I understand that the revocation will not apply to information already released based on this authorization.

Other rights:

(a) I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied.

(b) I understand that I may inspect or obtain a copy of the information to be used or disclosed.

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event or condition (If I do not specify an expiration date, event, or condition, this authorization will expire in 6 months.)

Signature of patient or legal representative	Date

If signed by legal representative, relationship to patient:	Print name of legal representative

Witness signature	Date