THOMAS A. DURNELL, MD

Womencare Associates

Dedicated to excellence in Women's Healthcare.

Authorization for Verbal Release of Protected Health Information

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Last: _____First: _____Middle:_____

Address: _____

Date of Birth: ____/____/_____ SS#: _____-____-_____ Phone ( ) _____

I _____ give my permission for **Thomas A. Durnell and/or Staff** to release information regarding appointment dates/times and my protected health information, including but not limited to , insurance, address, phone number, test results, health care information, and treatment to the following:

Name of Person: _____ Name of Person: _____

Relationship to Patient:_____ Relationship to Person: _____

Exceptions: _____ Exceptions: _____

Entity: _____ Entity: _____

I understand that:

- I may revoke this Authorization at any time, in writing. My revocation will not apply to information already retained, used or disclosed in response to this Authorization. Unless revoked the automatic expiration date will be _____ months from the date of the signature.
- Unless the purpose of this Authorization is to determine payment of a claim or benefits, the provision of treatment or payment for my care may not be conditions upon my signing of this Authorization.
- Information used or disclosed under this Authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.
- **THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE INFORMATION WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE DISEASE OR A NONCOMMUNICABLE DISEASE.**
- The information authorized for verbal release also may include protected health information related to mental health.
- The information/records is protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit anyone receiving this information or records from making further release unless further release is expressly permitted by 42 CRF Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. As a result, by signing below I specifically authorize any such records included in my health information to be released.

_____ _____ _____

Signature of Patient, Parent, or Legally Authorized Representative | Date | Relationship

_____ _____

Witness | Date