AUTHORIZATION TO DISCLOSE
PROTECTED HEALTH INFORMATION

DATE: _____

PATIENT NAME: _____

DATE OF BIRTH: _____

> As required by the Privacy Regulations, this practice may not use or disclose your protected health information except by your authorization.

I hereby authorize Alamo Women's Health to disclose my Patient Health Information to the following person(s), entities, or business associates of this office:

Print Authorized Person Name	Date	Signature of Authorized Person	Relationship

Print Authorized Person Name	Date	Signature of Authorized Person	Relationship

Effective date of this authorization ____/____/_____ through ____/____/_____
*This authorization will expire one year from above date.
I further understand that the information disclosed above may be re-disclosed to additional parties by the individuals named above and Alamo Women' Health will no longer be responsible due to my authorization to above action.
*I understand that health information or results cannot be disclosed over the phone, the parties listed above, must come by the office, and provide proper identification, prior to receiving any information.

I understand that I have the right to:

1. Revoke this authorization by providing a written notice to this office, and that revocation will not affect this office's previous reliance on the uses on the uses or disclosure pursuant to this authorization.
2. Refuse to sign this authorization.
3. Receive a copy of this authorization.

I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health information.

_____ _____
Signature of Patient Date

_____
Authorized Staff/Facility Signature