Associates For Women's Care
3213 Summit Square Place • Suite 200 • Lexington, KY 40509
Phone: 381-1066 Fax: 263-0650

AUTHORIZATION FOR USE AND DISCLOSURE OF INFORMATION AND IMAGES

YOU MUST COMPLETE EVERY SECTION BELOW OR THIS FORM MAY BE RETURNED TO YOU TO BE COMPLETED

1. Identity: Patient Name: _____ Social Security Number: _____

Address: _____ Date of Birth: _____

_____ Phone number: _____

2. Sender and Receiver:
I authorize disclosure of medical information (as indicated):

From: (Facility to Disclose Records)
Associates for Women's Care
213 Summit Square Place Ste. 200
Lexington, KY 40509

Disclose To: _____

3. Timeframe: I would like records from the following dates: _____ through _____.

4. What to disclose: Please check the records you would like disclosed:

HOSPITAL

- ☐ Records related to (specify): _____
- ☐ Discharge summary
- ☐ X-Ray Report(s)
- ☐ X-Ray Film(s)
- ☐ ER Notes
- ☐ Other: (specify) _____
- ☐ Operative Report(s)
- ☐ Pathology Report(s)
- ☐ Laboratory Report(s)
- ☐ Photo/Video/Other

OUTPATIENT FACILITY/LOCATION
(Indicate from choices on back): _____

- ☐ Records related to (specify): _____
- ☐ Out patient notes
- ☐ Laboratory Report(s)
- ☐ OB/GYN Notes/Reports
- ☐ TB screening
- ☐ X-Ray Report(s)
- ☐ X-Ray Film(s)
- ☐ Psychological test report
- ☐ Other: (specify) _____
- ☐ Pathology Report(s)
- ☐ Immunization Record
- ☐ Photo/Video/Other

5. Type of Disclosure: Paper Copies: (☐ Delivered by Mail *OR* ☐ Picked up by Receiver) ☐ Onsite Review ☐ Permission to Discuss Care

6. Disclosure of special protected records: I authorize the disclosure of information pertaining to:

a. The diagnosis or treatment of AIDS, including the results of HIV tests (the virus that causes AIDS) ☐ YES ☐ NO/NA
b. The diagnosis or treatment of drug and/or alcohol abuse ☐ YES ☐ NO/NA
c. Treatment and/or consultation for mental health or psychiatric disorders ☐ YES ☐ NO/NA

7. Purpose of Use/Disclosure: Please indicate/describe each authorized purpose of the use or disclosure:

☐ Request of individual ☐ Marketing (Identify/describe entity/program to be marketed) _____
☐ Public Relations/ News/Media ☐ Other (specify) _____.

8. Expiration date: This authorization will expire in 90 days or _____, which ever occurs last.

- I understand that I may revoke this Authorization at any time, unless the Authorization was obtained as a condition of obtaining insurance coverage; that my revocation must be submitted in writing to the Registration Office at the Facility/location where I originally submitted/filed this authorization; and that the revocation shall be effective *except* to the extent that the Facility has already used or disclosed information in reliance on the Authorization.
- I further understand that treatment, payment, enrollment in any health plan, or eligibility for benefits is not conditioned on signing this Authorization, however, Facility may condition the provision of health care that is solely for the purpose of creating protected health information for disclosure to a third party on my signing this Authorization, and Facility may condition the provision of research-related treatment on my signing this Authorization.
- I understand that information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by applicable privacy law. I further understand that the facility, its employees, officers and agents are released from legal responsibility or liability for the use and disclosure of the above information to the extent indicated and authorized.

I HAVE READ AND UNDERSTAND THIS INFORMATION. I HAVE RECEIVED A COPY OF THIS FORM AND I AM THE PATIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS DOCUMENT VERIFYING AUTHORIZATION FOR THE USE OR DISCLOSURE OF THE PROTECTED HEALTH INFORMATION UNDER THE ABOVE STATED TERMS.

_____ Date

_____ Signature of Patient

If patient is unable to sign, secure consent of Legal Representative and indicate reason below:
☐ Minor ☐ Incompetent ☐ Deceased
Proof of designation must be filed in the chart or sent with this request.

_____ Signature of Legal Representative and Relationship to Patient

_____ Signature of Witness for Psychiatric Records