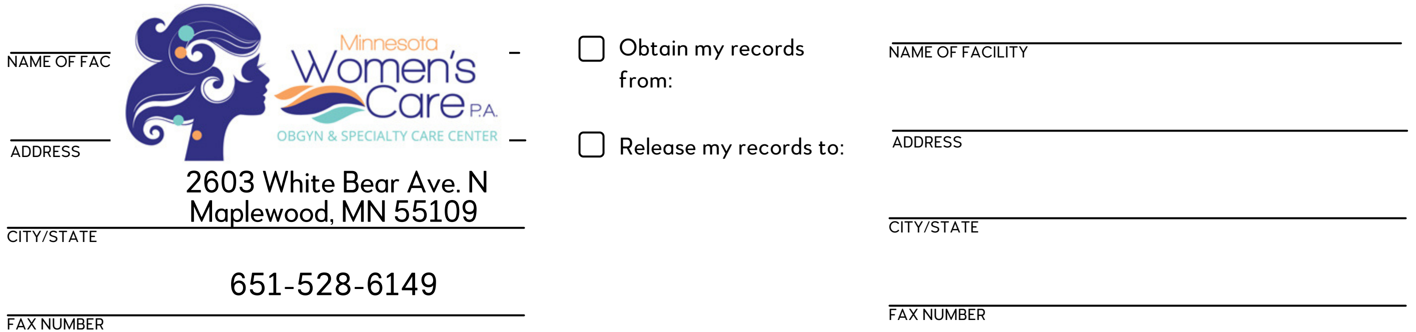
# AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

**COMPLETE ALL SECTIONS, SIGN, AND DATE**

I. I, ______________________________ (Name of patient) ____/____/____ (Date of Birth) hereby voluntarily authorize the disclosure of information from my health record.

II. I hereby authorize:




NAME OF FAC: Minnesota Women's Care P.A.

ADDRESS: 2603 White Bear Ave. N

CITY/STATE: Maplewood, MN 55109

FAX NUMBER: 651-528-6149

☐ Obtain my records from:

☐ Release my records to:

NAME OF FACILITY ______________________________

ADDRESS ______________________________

CITY/STATE ______________________________

FAX NUMBER ______________________________

III. The purpose or need for this disclosure is:

☐ Transfer of Care ☐ Additional Care ☐ Other (please specify) ______________________

IV. The information to be disclosed from my health record: (check appropriate box(es))

- ☐ Entire Record
- ☐ Only information related to (specify) ______________________
- ☐ Lab Result (specify ALL or specific lab(s)) ______________________
- ☐ Only the period of events from ____________ to ______________________
- ☐ FMLA/STD
- ☐ Other (specify) (billing, etc.) ______________________

Please select what sensitive information you DO want disclosed:

- ☐ Sexually Transmitted Diseases
- ☐ Mental Health (Other than Psychotherapy Notes)
- ☐ Alcohol/Drug Abuse Treatment/Referral
- ☐ HIV/AIDS-related Treatment

______________________________

Signature: Sensitive Information Consent

V. I understand that I may revoke this authorization in writing submitted at any time, except to the extent that action has been taken in reliance on this authorization. If this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, other law may provide the insurer with the right to contest a claim under the policy. If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or expiration event is stated.

______________________________

(Specify a new expiration date to extend or shorten the standard one year expiration (optional))

I understand that MWC will not condition treatment or eligibility for care on my providing this authorization except if such care is" (1) research related or (2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party.

I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164], and the Privacy Act of 1974 [5 USC 552a]

| SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE (STATE RELATIONSHIP TO PATIENT) | DATE |
| --- | --- |
| | |

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose. Any person who knowingly and willfully requests or obtains any record concerning an individual from a Federal agency under faulse pretenses shall be gulity of a misdemeanor (5 USC 552a(i)(3)).

Minnesota Women's Care

2603 White Bear Ave. N
Maplewood, MN 55109

Fax: 651-528-6149
Phone: 651-600-3035



Patient Label