

Stark County Women's Clinic, Inc.

Phone: 330-493-0313 / Fax: 330-494-9349

Authorization for Release of Protected Health Information

I, _____, _____/_____/_____, _____-____-_____, authorize
(print patient's name) (birthdate) (Social Security No.)

Stark County Women's Clinic, Inc. ("SCWC"), to disclose to, or request from, the following person/entity, the protected health information described below in accordance with this authorization:

(name of other person or organization)

(street address)

(city, state, zip)

BY: Mail
 Fax at _____
 Will pick up on: _____
 Other: _____

PROTECTED HEALTH INFORMATION TO BE DISCLOSED:

1. I authorize all information in my medical record from (date) _____ to (date) _____ to be disclosed according to the terms of this Authorization.
2. In addition, please release x-rays of (body part) _____. Yes No
3. In addition, I authorize the following protected health information to be disclosed according to the terms of this Authorization: _____.

INITIAL ONE OF THE FOLLOWING:

- _____ I consent to the disclosure of any information pertaining to alcohol abuse, drug abuse, psychiatric condition, any condition related to sexually transmitted disease and/or HIV (Human Immunodeficiency Virus) and AIDS (Acquired Immune Deficiency Syndrome).
- _____ **I do not consent** to the disclosure of any information pertaining to alcohol abuse, drug abuse, psychiatric condition, any condition related to sexually transmitted disease and/or HIV (Human Immunodeficiency Virus) and AIDS (Acquired Immune Deficiency Syndrome).

FOR THE PURPOSE OF: _____ Continued Care _____ Personal Use _____ Other: _____

- 1.) This authorization shall be in full force and effect for (60) sixty days from the date of the signing, at which time this authorization shall expire.
- 2.) My permission is extended only for the purpose as stated on this authorization and I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Stark County Women's Clinic, Inc., at 5000 Higbee Avenue NW, Canton, Ohio 44718. I understand that a revocation is not effective to the extent that SCWC has relied on the use or disclosure of the protected health information.
- 3.) I understand that I will be responsible for any charges incurred for the copying and/or faxing of my medical record as permitted by law. _____ (initial)
- 4.) I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. If SCWC is receiving the information, SCWC will only use or disclose the information as permitted by law or as authorized by you.
- 5.) SCWC will not condition my treatment on whether I provide authorization for the requested use or disclosure.
- 6.) I understand I have the right to refuse to sign this authorization. I further understand that I have the right to inspect or copy the protected health information to be used or disclosed as permitted under law.

(signature of patient or guardian) (relationship to patient) (date)

(address) (home phone number)

(city, state, zip) (work phone number)