

SANDPOINT WOMEN'S HEALTH
AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION
(To be initiated by the patient or the patient's legal representative)

Patient Name: _____ Date of Birth: _____

Social Security #: _____

Address: _____ Phone: _____

City, State, Zip Code: _____

I hereby authorize the use and disclosure of individually identifiable health information relating to me, otherwise known as "protected health information" or "PHI" under a federal privacy law, as described below. I understand this authorization is voluntary. I consider a copy of this authorization to be as valid as the original. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulations.

Person(s)/organization(s) providing the information:

Name and address of person(s)/organization(s) receiving the information:

Sandpoint Women's Health
420 N 2nd Avenue
Sandpoint, ID 83864
(208) 263-2173
Fax (208) 263-7441

Specific description of information to be released including date(s) and type(s) of service: _____

Purpose for which information is to be used:

Treatment Insurance Personal Follow up
 Legal Other (specify:)

(Continued on back)

I specifically authorize the release of date and information relating to (please initial appropriate box below) and hereby release the providing person(s)/organization(s) from all legal liability that might arise from the release of sensitive information protected by Title 42 of the Code of Federal Regulations.

- Substance Abuse (alcohol or drug abuse)
- Behavioral Health (except psychotherapy notes which require a specific authorization)
- HIV or other sexually transmitted disease related information (or AIDS-related testing).

I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it, by writing to the providing person(s)/organization(s) listed on the front of this form.

Without my written permission to revoke this authorization, it will expire 180 days from the date of signature. If you desire a specific date (not to exceed 6 months) or event upon which this authorization will expire, please specify:

I understand that I am entitled to a copy of this authorization form. I understand that I have the right to inspect or receive copies of my Protected Health Information (PHI) to be used and/or disclosed under this authorization, and that a fee for copies may be imposed by the provider person(s)/organization(s) or its designated business associate.

Please Note: This information may have been disclosed from records whose confidentiality is protected by federal law. Federal regulation 42 C.F.R. Part 2 prohibits any person(s)/organization(s) from making any further disclosure without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations.

Signature of Patient or Patient's Legal Representative

Date

Printed Name of Patient's Legal Representative

Relationship of Legal Representative to Patient