Visalia Women's
Specialty Medical Group, Inc.

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

I hereby authorize the use or disclosure of my Protected Health Information described below. I understand that this authorization is voluntary. I understand that the released information will no longer be protected by federal privacy regulations.

Patient Name: _____ S.S. Number_____

Persons who may receive the information:

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

Information that may be released:

( ) Personal Contact Information Only

( ) Personal Information and Details of Gynecology Studies with Results

1. I understand that I may see and copy the information described on this form if I ask for it and that I will be given a copy of this form after I sign it.

2. I understand that this authorization will start on (indicate dates) ___/ ___/ ___/ and expire on ___/ ___/ ___
Note: If you do not indicate the dates above, we will use the signed date below as start date and not revoke this authorization until you notify us in writing. Initials: _____

3. I understand I may revoke this authorization at any time by notifying Visalia Women's Specialty Medial Group, Inc. in writing, but if I do I will not have any effect on any actions they have taken before receiving the revocation. Initials: _____

_____ _____
Signature of Patient or Authorized Personal Representative Date

_____ _____
Signature of Witness Date