

Standard Authorization of Use and Disclosure of Protected Health Information

Patient Name: _____ **DOB:** _____

Information to Be Used or Disclosed

The information covered by this authorization includes:

Complete Record: _____ Specific Record: _____
Sensitive Information: ___Abortion ___Abuse ___AIDS/ARC ___Alcohol Abuse ___Hepatitis ___Infertility
___Mental Health Visits ___Sexual Abuse/Assault/Rape ___Substance Abuse
___Other (Please Specify) _____

Purposes of Disclosure

Information listed above will be disclosed for the following purposes:

___Leaving WWC ___Personal Records ___Insurance Company ___2nd Opinion/Consult/Referral
___Other (Please Specify) _____

Persons Authorized to Use or Disclose Information

Information listed above will be **disclosed by**:

Wellesley Women's Care
Name of person/organization

Name of person/organization

Name of person/organization

Persons to Whom Information May Be Disclosed

Information described above may be **disclosed to**:

Name of person/organization

Street Address

City/State/Zip Code

Expiration Date of Authorization

This authorization is effective through ___ / ___ / ___ unless revoked or terminated by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to **Wellesley Women's Care**. You should contact the **Practice Manager** to terminate this authorization.

Potential for Re-disclosure

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. If may not be possible to ensure your right to the protection of the privacy of this information once **Wellesley Women's Care** discloses it to another party.

Rights of the Individual

You may inspect or copy information used or disclosed under this authorization. You may refuse to sign this authorization.

Effect of Refusing Authorization

If you refuse to sign this authorization, **Wellesley Women's Care** will not deny you any treatment except research-related treatment that you have requested for the purpose of disclosure to others, including:

Treatment conditioned on authorization

Treatment conditioned on authorization

Signature

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Name of Patient (print or type) **Signature of Patient** **Date**

Signature of Patient Representative

Relationship of Patient Representative to Patient