PRESIDENTIAL
Women's Center
Excellence In Women's Healthcare
For Over 35 Years

Authorization for Use or Disclosure of Health Information

I hearby authorize Presidential Women's Center to use or disclose the following information from the health record of:

_____ _____
Name (please print) Date of Birth

Contact Phone or Email _____

For date(s): _____ through _____

Information to be disclosed:

_____ Sonogram _____ Medical History _____ Consent forms

_____ OR note _____ Recovery Room note _____ Pathology report

_____ Follow-up note _____Progress notes _____ Lab slip

_____ Pregnancy Test _____ Other (please specify)_____

This information is to be used for or disclosed to: _____

for the purpose of: _____.

I understand this information will be used or disclosed by the Privacy Officer or _____.

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire thiry (30) days from today's date.

Note: To revoke this authorization, you must complete the Revocation of Authorization form.
I understand that once the information has been disclosed it may be redisclosed by the recipient. This redisclosure will not be subject to the Privacy Policies of Presidential Women's Center.

Presidential Women's Center, its' employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

_____ _____
Signature Date

_____ _____
Witness Date

100 Northpoint Parkway | West Palm Beach, FL 33407
Phone: 561.686.3859 | Fax: 561.686.4755
www.presidentialcenter.com