



**Authorization for Use or Disclosure of Health Information**

I hereby 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 thirty (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