



Authorization for Use or Disclosure of Health Information

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

Name (please print)

Date of Birth

Contact phone number 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: Continuation of Care

Personal Records

Legal

Medical Clearance

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, LP.

Presidential Women's Center, LP, it's 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