MT AUBURN OB-GYN ASSOC., INC.
Authorization to Use or Disclose Health Information for Purposes Unrelated to Treatment, Payment or Healthcare Operations

Patient Name:_____

Medical Record Number:_____

Date of Birth:_____/_____/_____ Social Security No._____-_____-_____

1. I authorize the use or disclosure of the above named individual's health information as described below.

2. The following individual(s) or organization(s) are authorized **TO MAKE** the disclosure:

_____

_____

_____

_____

3. The type of information to be used or disclosed is as follows (check the appropriate boxes and include other SPECIFIC information where indicated)

- ☐ problem list
- ☐ medication list
- ☐ list of allergies
- ☐ immunization records
- ☐ most recent history
- ☐ most recent discharge summary
- ☐ lab results (please describe the dates or types of lab tests you would like disclosed):
- ☐ x-ray and imaging reports (please describe the dates or types of x-rays or images you would like disclosed):
- ☐ consultation reports from (please supply doctors' names):
- ☐ entire record
- ☐ other (please specifically describe):_____

_____

_____

_____

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

5. The information identified above may only be **USED BY OR DISCLOSED TO** the following individual or organization(s):

Name:_____ Phone_____

Address:_____

Name:_____ Phone_____

Address:_____

6. This information for which I'm authorizing disclosure will be used for the following SPECIFIC purpose:

- ☐ my personal records
- ☐ sharing with other health care providers as needed
- ☐ other (please specifically describe): _____

_____

_____

_____

7. I understand that I have a **RIGHT TO REVOKE THIS AUTHORIZATIO AT ANY TIME.** I understand that if I revoke this authorization, I **must do so in writing** and present my written revocation to the Practice's Privacy Officer. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

8. This authorization will expire (insert SPECIFIC date or event):_____

_____

_____

If I fail to specify an expiration date or event, this authorization will expire six months from the date on which it was signed.

9. I understand that once the above information is disclosed, the receiver of the information disclosed may redisclose it and federal privacy laws or regulations may not protect it and the information.

10. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

_____ _____

Signature of patient or legal representative Date

If signed by legal representative, relationship to patient _____

_____ _____

Signature of witness Date