SHARP & STONE OB/GYN, P.C.
2700 10TH AVENUE SOUTH, SUITE 306 BIRMINGHAM, AL 35205
PHONE (205)933-4020 FAX (205)933-4022

Patient Authorization to Use or Disclose Protected Health Information

Patient Name:_____ Date:_____

Social Security #:_____ Date of Birth:_____ Patient Phone #:_____

I understand Sharp & Stone OB/GYN, P.C. is authorized by me to use or disclosure my protected health information for a purpose other than treatment, payment, or health care operations. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipient(s) of that information. I specifically authorize any current employee or owner of Sharp & Stone OB/GYN, P.C., or any other individual listed below to disclose my protected health information as described on this form to the recipients listed below. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information. I further understand that I retain the right to revoke this authorization, if done so according to the steps set forth below.

The following organization is authorized to make the disclosure:

Release records from:_____

_____

_____

Description of the information to be used or disclosed *(check all that apply)*:

[ ] The patient's entire medical record
(NOTE: This requires an explanation why the entire record may be disclosed).

[ ] The patient's demographic information *(check all that apply)*:
[ ] Name [ ] Address [ ] State/Zip Code only [ ] Telephone
[ ] Age[ ] Gender [ ] Race [ ] Other: _____

[ ] Medical Data/Information as related to:
[ ] Specific condition, service or medication(s): _____
_____

[ ] Other: _____
_____

Please release the above information to the following physician or individual(s):

Release records to:_____

_____

_____

The patient has a right to revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization or, if applicable, during a contestability period. In order for the revocation of this authorization to be effective, Sharp & Stone OB/GYN, P.C. must receive the revocation in writing. ALL revocations must be sent to Sharp & Stone OB/GYN, P.C. to the attention of the Privacy Officer, and are not effective until received by the Privacy Officer.

This authorization shall expire on _____. After this date, Sharp & Stone OB/GYN, P.C. can no longer use or disclose the patient's protected health information without first obtaining a new authorization form. If I fail to specify a date, this authorization will expire 1 year from today's date.

I fully understand and accept the terms of this authorization.

_____ _____

Patient's Signature Date

AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION

Please understand that it may be necessary for us to release some or all of the information contained in your medical records to other physicians, nurses, and/or healthcare providers. At times, other providers assist us in assessing a patient's conditions, screening for potential problems or providing consultation under certain circumstances. All healthcare providers are required by law to keep your information confidential.

Also, due to the increased awareness of quality of care, it may be necessary to disclose information regarding your care to healthcare agencies, both private and governmental. Your insurance company and/or your self-insured employer are such agencies. Regarding the information going to your employer other than information needed to verify your insurance coverage, the data released will consist of statistical information only.

_____ I ***do not*** wish to have test results or other medical information released to any person(s) other than myself.

_____ I ***do*** wish to have test results or other information released to the following person(s). These individuals are people <u>other than</u> medical personnel.

_____ Relationship _____

_____ Relationship _____

_____ Relationship _____

_____ Relationship _____

It is the responsibility of the patient to notify this office of any changes to the above information if changes do occur. It will be necessary to complete another Authorization form with the updated information.

_____ _____

Patient Signature Date

_____

Printed Name

At Sharp & Stone OB/GYN, we take great pride in being a part of your pregnancy and delivery. If at any point you wish to send us (or have already sent us) any personal photographs, holiday cards, birth announcements, etc., we will proudly display them in our office. Please be aware that these items may be visible to persons who are not employed in the practice. Your signature below indicates your understanding of this policy.

_____ _____

Patient Signature **Date**