

HIPAA COMPLIANT PATIENT AUTHORIZATION FORM

TO: _____

I hereby authorize you to use or disclose the specific information described below, only for the purpose and parties also described.

Description of the specific information to be used or disclosed:

- | | | |
|---|--------------------------------------|-------------------------------------|
| <input type="checkbox"/> Office Notes (may include any psychotherapy notes) | <input type="checkbox"/> Pap Smears | <input type="checkbox"/> X- Rays |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Labs | <input type="checkbox"/> Mammograms |
| <input type="checkbox"/> Hospital Summary | <input type="checkbox"/> Pathology | <input type="checkbox"/> Other |
| <input type="checkbox"/> Operation Reports | <input type="checkbox"/> Ultrasounds | |

Person or entity requesting the information and authorized to make the requested use or disclosure:

Pineview Gynecology, 1322 Pineview Drive, Morgantown, WV 26505

Phone # 304/599-8790

Fax # 304/599-8795

Recipient of the information: _____

The information is being requested for the following purpose(s):

This authorization shall remain in effect from the date signed below until 1 YEAR (expiration date or event)

I understand that:

- I may inspect or copy the protected health information to be used or disclosed.
 - I may revoke this authorization in writing by contacting your office at the address above, attention Privacy Officer.
 - Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer protected by HIPAA.
 - I may refuse to sign this authorization and that you will not condition treatment or payment on me providing this authorization (except to the extent that the authorization is for research-related treatment, in which case you may refuse to provide that research-related treatment).
- If this box is checked, I understand that you will receive compensation from a third party for the use or disclosure of my information.

Patient Name: _____ **Signature:** _____

Social Security Number: _____ **Date of Birth:** _____

Relationship to Patient: _____ **(if signed by personal representative of the patient)**

Patient: _____ **Chart #** _____ **Date:** _____