

WOMEN'S CLINIC, LTD.
301 S. 7th Avenue, Suite 245
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PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF
PROTECTED HEALTH INFORMATION TO PATIENT-APPROVED ENTITIES

By specifying an individual, I authorize the Women's Clinic, Ltd. to use and/or disclose protected health information (PHI) about me to persons or groups named below other than physicians.
Provide a date of birth or other identification for any persons listed.

Spouse / Significant Other & birth date _____
Other family member & birth date _____
Unrelated person(s) & birth date _____

This authorization permits the Women's Clinic, Ltd. to use and/or disclose the following individually identifiable health information about me. **Please read the selections carefully and check only the boxes that apply.**

Women's Clinic staff may leave messages on an answering machine/voicemail specifying a call "Women's Clinic" vs. saying "your doctor's office."

This call may be placed to my cell phone, my home phone, or my work phone.

Women's Clinic may leave messages with another person **as specified/named above** about medications or other treatment or test results.

Other (please be specific, i.e., disability insurance carrier, etc.) _____

The following statement means that we will not share any information with any person other than you.

I do not want any protected health information shared with others.

When my information is used or disclosed pursuant to this authorization, it may be subject to disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. A copy of the HIPAA Privacy Rule is available at our front desk upon request.

By signing, I acknowledge that I have received the appropriate HIPAA compliance information and that I have read and understand this authorization. I authorize use and disclosure of health information about the named patient as described in this authorization.

Signed by:

Patient Date

Legal Guardian Date