AUTHORIZATION TO USE AND/ OR DISCLOSE HEALTH INFORMATION

Today's Date: _____

Patient Name: _____ Date of Birth: _____

I authorize _____ (Person to whom we need records from) to use or disclose my health information as described below.

1. **Type of Information**: The type of information to be used or disclosed is as follows (check the appropriate spaces and include other information where indicated):
   _____ The Entire Medical Record
   _____ Business Office Info
   _____ Physician Office Notes/ Nurse Notes
   _____ History & Physical
   _____ Medication and Treatment Records
   _____ Diagnostic Info (Labs, X-ray, Ultrasounds)
   _____ Other (Describe as specifically as possible): _____

2. **Recipient of Information:** The information identified above may be used by, or disclosed to, the following individual(s) or organization(s):
   _____ Susan S. Westerlund, M.D. & Richard E. Stephens Jr, M.D.
   860 Brookstone Center Pkwy Suite 200
   Columbus, GA 31904
   Phone: (706) 507- 4243
   Fax: (706) 507- 4743

3. **_____ Other:** Name: _____
   Phone: _____ Fax: _____
   _____ Initiated at the request of the patient
   _____ My personal Records
   _____ Sharing with other health care providers as needed
   _____ Other (Please Describe): _____

Authorization statements/ signatures:

4. _____ I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the HIPAA Privacy Rule may no longer protect the information.
5. For Marketing disclosures only: (Check is applicable) _____ I understand that I will receive compensation related to the use or disclosure of the requested information.
6. _____ I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to **Women's Health and Wellness** (physician) I understand that the revocation will not apply to information that has already been released in response to this authorization.
7. Unless I specify differently, this authorization will expire in 1 year from the date of the signature. I understand that **Women's Health and Wellness** will not condition the provision of treatment or payment on the provision of this authorization.

X Electronic, _____ Paper, _____ CD, _____ Email, _____ I wish to pick up my records.
Print Name: _____
Signature of Patient or Personal Representative: _____
Date: _____