

Obstetrics & Gynecology Associates, P.A.

610 Oak Commons Blvd.

Kissimmee, FL 34741

407-846-7200 Fax: 407-846-3989

**AUTHORIZATION FOR USE OR DISCLOSURE
OF PROTECTED HEALTH INFORMATION**

Full Name: _____

Date of Birth: _____

This is an authorization under the Privacy Rules of the Health Insurance Portability and Accountability Act of 1996 [45 CFR § 164.508]. I authorize Obstetrics & Gynecology Associates, P.A., my physician and/or administrative and clinical staf

__ use the following protected health information, and/or

__ disclose the following protected health information to [*Name of entity or class of persons to receive information*]:

__ receive from _____ the following protected health information:

The information to be used or disclosed is as follows: [*Specifically and meaningfully describe the protected health information to be used or disclosed such as date of service, type of service, level of detail to be released, origin of*

This protected health information is being used or disclosed for the following purposes: [*List specific purposes here. "At the request of the individual" is acceptable if the request is made by the patient, and the patient does*

This authorization shall be in force and effect until: (1) _____ [*expiration date*] date or (2) _____

[*event that relates to the patient or the purpose of the use or disclosure*] at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Officer at 610 Oak Commons Blvd., Kissimmee, FL 34741. I understand that a revocation is not effective

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

My physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except: (1) if my treatment is related to research, or (

If the use/disclosure is for marketing, I understand that the use or disclosure requested under this authorization will result in direct or indirect remuneration to my physician from a third party. _____ [*Patient Initials if applicable*]

Signature of Patient or Personal Representative

Date

Print Name of Patient or Personal Representative

Description of Personal Representative's Authority