Sierra Women's Health

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize:

- _____
- _____
- _____

to use and/or disclose certain protected health information (PHI) about me to:

- _____
- _____
- _____

This authorization permits the use and/or disclosure of the following individually identifiable health information about me:

_____

_____

The information will be used or disclosed at my request. This authorization will expire upon the receipt of the information by the named recipient.
I understand that when my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization.

( ) Please FAX the requested information to:_____
FAX Number

I understand that Sierra Womens Health has no control over who may access this information once it arrives at the designated FAX number that I have provided.

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____ _____
Print Patient's Name Social Security Number Date of Birth

_____ _____
Print Legal Guardian's Name (if applicable) Relationship to Patient

_____
Witness Signature