HIPAA PRIVACY AUTHORIZATION

Patient Name: _____ Date of Birth: _____

Patient Address: _____

_____

I hereby authorize WOODLANDS WOMEN'S CARE to release my Protected Health Information to the following individual(s):

☐ **DO NOT disclose my Protected Health Information to anyone other than myself.**

1. _____ Relationship: _____

2. _____ Relationship: _____

3. _____ Relationship: _____

Authorized phone number(s) to contact you:

Cell #_____Work #_____Home #_____

Patient Email: _____

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to the address below:

1120 Medical Plaza Dr., Suite 255 The Woodlands, TX 77380

I understand that a revocation is not effective to the extent that the practice has relied on this authorization in its actions. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy or the policy itself. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations.

The practice will not condition my treatment, payment, and enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____ _____

Signature of Patient or Personal Representative Date