ASHEVILLE WOMEN'S MEDICAL CENTER
143 ASHELAND AVENUE
ASHEVILLE, NC 28801
PHONE: (828) 258-9191 FAX: (828) 253-7382

PATIENT 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 disclosure of the following individually identifiable health information about me:

_____ **ALL NEW PATIENTS:** Last three pap smear/co-testing results. And, if applicable, last breast imaging reports, last bone density report, last colonoscopy report

_____ All OB/GYN Relevant Records

_____ Specific Information _____

_____ Specific Information to be excluded _____

****All types of information found in the records selected above will be provided (if applicable), including information that may be viewed as sensitive; such as alcohol, drug abuse, genetic information, psychiatric, STD testing and/or results, HIV testing, HIV results or AIDS information. Specify any information above you would like to have excluded.**

The information will be used or disclosed for the following purpose:

_____ Changing Physicians _____ Additional Physicians _____ Insurance Claim

_____ At my request _____ Other (Specify) _____

THIS AUTHORIZATION WILL AUTOMATICALLY EXPIRE ONE YEAR FROM THE DATE SIGNED.

I do not have to sign this authorization in order to receive treatment from Asheville Women's Medical Center. In fact, I have the right to refuse to sign this authorization. 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. My written revocation must be submitted to the Privacy Officer at: 143 Asheland Avenue, Asheville, NC 28801.

Signed by:

_____ _____
Signature of Patient or Legal Guardian Relationship to Patient

_____ _____
Mailing Address City State Zip Code

_____ _____
Print Name of Patient or Legal Guardian Last 4 digit SSN

_____ _____
Date of Birth Date Telephone Number

_____ _____
Witness Medical Record Number/ Provider

NOTE: Federal and State laws permit a fee to be charged for the copying of patient records. Currently, the charge is $0.75 (1-25 pgs) $0.50 (26-100) $0.25 (101+) plus actual postage for the Patient Personal Requests. Prices are subject to change without notice.