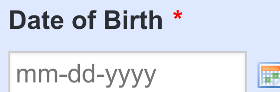
Confidential Communication of Protected Health Information

Patient Name *

First Name | Last Name

SSN (last four digits) *

Date of Birth *



Account #

Chose **ONE** of the two options below.

OPTION 1

☐ Option 1 - I authorize Alliance Obstetrics & Gynecology, PPLC to disclose or provide protected health information, about me, to individual(s) listed below:

Individual 1

Name

Relationship

Phone

I authorize the practice to disclose the following protected health information to the individual listed above.

☐ Entire Record ☐ Billing Infomation ☐ Office Notes ☐ Labs or ultrasound

Individual 2

Name

Relationship

Phone

I authorize the practice to disclose the following protected health information to the individual listed above.

- [ ] Entire Record
- [ ] Billing Information
- [ ] Office Notes
- [ ] Labs or ultrasound

Individual 3

Name	Relationship	Phone

I authorize the practice to disclose the following protected health information to the individual listed above.

- [ ] Entire Record
- [ ] Billing Information
- [ ] Office Notes
- [ ] Labs or ultrasound

- This authorization will expire 3 years from date of signature in which the authorization was initiated, unless you specify an earlier termination. You must submit a new authorization after the expiration date to continue the authorization. Please list the date of expiration if earlier than the 3 year expiration date:

Expiration Date mm-dd-yyyy

- You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.
- The practice places no condition to sign this authorization on the delivery of healthcare or treatment.
- We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of the practice.

OPTION 2

- [ ] Option 2 - I decline to authorize Alliance Obstetrics & Gynecology, PLLC to disclose or provide protected health information about me to any individual(s).

Patient Signature *

Clear

Submit

Copies of signed authorizations are available upon request. Form Revised 7/6/17