Plano Women's Healthcare, P.A.
1600 Coit Road, Suite 202; Plano, TX 75075
Fax# 972-596-6526

Authorization to Disclose Health Information

Client Name_____ Date of Birth_____

Client Medical Record #_____Client SS# (*Optional*) _____

I _____ hereby authorize
(*Client or Personal Representative*)

_____ to disclose specific health information
(*Name of Provider*)

from the records of the above named client to: _____
(*Recipient Name/Address/Phone/Fax*)

_____

_____

for the specific purpose(s): _____

_____

Specific information to be disclosed: _____

_____

_____

I understand that this authorization will expire on the following date, event or condition: _____

_____

_____I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosures for financial transactions, wherein the authorization is valid indefinitely. I also understand that I may revoke this authorization at any time and that I will be asked to sign the *Revocation Section* on the second page of this form. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

_____I understand that my information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

_____I understand that if my record contains information relating to HIV infection, AIDS, or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing this disclosure will include that information. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given.

_____I am aware that a fee for copying my records may apply.

_____I further understand that I may request a copy of this signed authorization.

_____	_____	_____
(*Signature of Client*)	(*Date*)	(*Witness-If required*)
_____	_____	_____
(*Signature of Personal Representative*)	(*Date*)	(*Personal Representative Relationship/Authority*)

NOTE: This Authorization was revoked on _____ _____
(*Date*) (*Signature of Staff*)

REVOCATION SECTION

I do hereby request that this authorization to disclose health information of _____
(*Name of Client*)

signed by _____ on _____
(*Enter Name of Person Who Signed Authorization*) (*Enter Date of Signature*)

be rescinded, effective _____. I understand that any action taken on this authorization prior to the
(*Date*)

rescinded date is legal and binding.

_____ _____ _____ _____
(*Signature of Client*) (*Date*) (*Signature of Witness*) (*Date*)

_____ _____ _____
(*Signature of Personal Representative*) (*Date*) (*Personal Representative Relationship/Authority*)

VERBAL REVOCATION SECTION

I do hereby attest to the verbal request for revocation of this authority by _____
(*Name of Client or Personal Representative*)

on _____. The client or his/her personal representative has been informed that any action taken on this

authorization prior to the rescinded date is legal and binding.

_____ _____ _____ _____
(*Signature of Staff Member*) (*Date*) (*Signature of Witness*) (*Date*)