Women's Health CONSULTANTS

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AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION- AMBULATORY SETTING

I,_____hereby authorize:

From: Physician's Name_____

Physician's Street Address_____

City_____State_____Zip_____

Phone number_____Fax _____

Its Director or Designee, or Health Information Management/Medical Records Department, to release protected health information, including alcohol and drug abuse records protected under the regulations in Title 42 Code of Federal Regulations, Part 2, if any: behavioral medicine services records, if any, including communications made by me to a social worker or psychologist; and any information regarding communicable diseases and infections as defined by MCLA 333.5131, if any, which includes venereal disease, tuberculosis, HIV, AIDS and ARC, to individuals or organizations listed below, only under the conditions listed below.

1. Name of person(s) or organization(s), to which disclosure is to be made:

To: Women's Health Consultants, PLC
46325 West 12 Mile Road, Suite 250
Novi, MI 48377
Fax- (248) 465-2850

Patient of Dr. _____

I understand that my protected health information disclosed under this Authorization may by subject to redisclosure by the individual or organization named above and its privacy will no longer be protected by the law.

2. The authorized person must place their initial next to the specific type(s) of information to be disclosed.

_____Office Records Dates of Service_____
_____Ultrasound Report Dates of Service _____
_____Laboratory Tests Dates of Service _____
_____Mammogram Report (no films) Dates of Service _____
_____Bone Density Records Dates of Service _____
_____Pap Smear Records Dates of Service _____
_____OB Records Dates of Service _____
_____Other- Describe records required and give approximate date(s) of service:

_____

_____

3. The purpose and need for such disclosure:

___Employers Request ___Disability Certification ___Continuation of Care
___Physician Request ___Insurance Claim ___Consultation
___Social Service ___Insurance Application ___School Requirement
___Worker's Compensation ___Attorney Inquiry ___Personal Use
___Other (specify)_____ ___Moving

4. This authorization can be revoked, in writing, at any time except to the extent that information has already been released or disclosed. Any authorization for the release or disclosure of drug and alcohol abuse records shall end when the purpose for the release has been achieved.

5. This authorization will expire automatically when the purpose for the release or disclosure has been achieved or upon 90 days after the date below, whichever is later.

Signature of Patient_____Date _____

Birth Date of Patient_____Phone number of Patient _____

Consent of legal guardian, patient advocate or personal representative if patient is incapable or is a minor.

Signature of guardian, patient advocate, or personal representative _____
Relationship_____Phone Number _____
Address_____
Witness _____