Limited Patient Authorization for Disclosure of Protected Health Information

Form 7.31

Please print all information. Form must be signed and dated.

Purpose of request (who will be authorized to receive information) - I authorize OAKDALE OB/GYN to disclose or provide protected health information, about me to the individual/entity listed below.

Who will be authorized to receive information (the individual/entity that is to receive your PHI):

Person	Relationship	Contact Number

* **Secure Communication** - Note that regular email is not secure, and it is possible for your PHI to be compromised during transmission from our practice. Do not designate email as your preferred method of disclosure if this is of concern to you. Oakdale OB/GYN may leave a message on an answering machine or voicemail of any designated phone number.

Description of information to be disclosed - I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

- ☐ Entire patient record; **or**, check **only** those items of the record to be disclosed:
- ☐ office notes
- ☐ lab results, pathology reports
- ☐ Only send the following: _____
- ☐ record of mental health or substance abuse treatment
- ☐ record of HIV and communicable disease testing

- This authorization will expire 12 months after signature, unless you specify an earlier termination. You must submit a new authorization form after the expiration date to continue the authorization. Please list the date of expiration if earlier than 12 months: _____
- 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.

_____ _____

Patient Name (Please print) Date of Birth

_____ _____

Patient or authorized representative signature date

You have the right to receive a copy of signed authorizations upon request.