AUTHORIZATION TO DISCLOSE INFORMATION FROM
ELIZABETHTOWN PHYSICIANS FOR WOMEN, P.S.C.

1115 WOODLAND DRIVE PHONE 270-769-5963
ELIZABETHTOWN, KY 42701 FAX 270-769-9051

******PLEASE COMPLETE THIS FORM IF YOU WOULD LIKE TO AUTHORIZE ANY INDIVIDUAL(S) TO RECEIVE INFORMATION ABOUT YOU. INFORMATION WILL NOT BE RELEASED TO ANYONE UNLESS YOU AUTHORIZE HERE.*********

Patient Name (Print)_____Social Security #_____
Date of Birth_____Other Last Names_____

I hereby authorize the disclosure of my individual health information, as described herein, to the Individual listed below. I understand that my authorization is voluntary and that it is provided to Elizabethtown Physicians for Women, PSC.

1. Full name(s) of individual(s) to receive information :_____

2. I understand the purpose of this disclosure is:
   _____At the request of the patient

3. The type of information to be used or disclosed is as follows (include dates where appropriate):
   A: _____Complete Medical Record (Including records related to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse).
   B: I hereby authorize the release of the following medical records:
   _____Laboratory Test(s) _____History/Physical
   _____Treatment Plan _____Medication History _____Discharge Summary
   _____Operative Report _____Diagnosis/Dates of Treatment _____Appt Times_____
   _____Alcohol & Other Drug Use, Abuse and/or Treatment Information _____Other_____
   _____Treatment Information which may include Human Immunodeficiency Virus (HIV) Infection, Acquired Immunodeficiency Syndrome (AIDS), or Tests for HIV.

4. This authorization shall expire five (5) years from this date.

5. Required Statements.
   a. I understand that I may revoke this authorization at any time in writing, upon my request, by signature of appropriate Revocation Form provided to me. However, my revocation will not have an effect on uses or disclosures made in reliance on my authorization before revocation.
   b. I understand that it is possible that information disclosed pursuant to my authorization may be subject to re-disclosure by the recipient of my health information and hence no longer protected by federal privacy regulations.

(FORM MUST BE COMPLETED BEFORE SIGNING)

_____ _____
Signature of Patient Date

_____ _____
Personal Representative Relationship

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