Stark Women's Center.

Phone: 330-493-0313 / Fax: 330-493-9349
5000 Higbee Ave * Canton, Oh 44718

Authorization for Release of Protected Health Information

I, _____, _____/_____/_____, _____-_____-_____, authorize
(print patient's name) (birthdate) (Social Security No.)
Stark Women's Center. ("SWC") , to ☐ **disclose to** , or ☐ **request from**, the following person/entity, the protected health information described below in accordance with this authorization:

_____ BY: ☐ Mail
(name of other person or organization) ☐ Fax at _____
_____ ☐ Will pick up on: _____
(street address) ☐ Other: _____
_____ _____
(city, state, zip)

PROTECTED HEALTH INFORMATION TO BE DISCLOSED: (MUST BE COMPLETED FOR RECORDS RELEASE)

_____ 1. I authorize all information in my medical record from (date) _____ to (date) _____ to be disclosed according to the terms of this Authorization.

INITIAL ONE OF THE FOLLOWING: (MUST BE COMPLETED FOR RECORDS RELEASE)

_____ I consent to the disclosure of any information pertaining to alcohol abuse, drug abuse, psychiatric condition, any condition related to sexually transmitted disease and/or HIV (Human Immunodeficiency Virus) and AIDS (Acquired Immune Deficiency Syndrome).

_____ **I do not consent** to the disclosure of any information pertaining to alcohol abuse, drug abuse, psychiatric condition, any condition related to sexually transmitted disease and/or HIV (Human Immunodeficiency Virus) and AIDS (Acquired Immune Deficiency Syndrome).

(MUST BE COMPLETED FOR RECORDS RELEASE)

FOR THE PURPOSE OF: _____ Continued Care _____ Personal Use _____ Dissatifaction: **Please explain**: _____

_____

_____

_____Moved _____Insurance Changes _____Second Opinion _____Financial _____Personal Preference

1.) This authorization shall be in full force and effect for (60) sixty days from the date of the signing, at which time this authorization shall expire.
2.) My permission is extended only for the purpose as stated on this authorization and I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Stark Women's Center., at 5000 Higbee Avenue NW, Canton, Ohio 44718. I understand that a revocation is not effective to the extent that SWC has relied on the use or disclosure of the protected health information.
3.) I understand that I will be responsible for any charges incurred for the copying and/or faxing of my medical record as permitted by law. _____ (initial)
4.) I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. If SWC is receiving the information, SWC will only use or disclose the information as permitted by law or as authorized by you.
5.) SWC will not condition my treatment on whether I provide authorization for the requested use or disclosure.
6.) I understand I have the right to refuse to sign this authorization. I further understand that I have the right to inspect or copy the protected health information to be used or disclosed as permitted under law.

_____ _____
(signature of patient or guardian) (relationship to patient) (date)

_____ _____
(address) (home phone number)

_____ _____
(city, state, zip) (work phone number)