

**Women's Pelvic Health & Continence Center**

An Affiliate of Obstetrical and Gynecological Associates, P.A.

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**Limited Patient Authorization for Disclosure of Protected Health Information**

**Form 7.31**

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

**Patient Name:** \_\_\_\_\_

**Social Security Number:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Purpose of request (who will be authorized to receive information)** - I authorize the practice to disclose or provide protected health information, about me, to: (please identify entity, person or persons who will receive the information):

**Entity Providing Information:**

Practice: \_\_\_\_\_

Provider: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

**Entity Receiving Information:**

Name: \_\_\_\_\_

\_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

**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: (please provide a written description of the information to be disclosed):

- Entire patient record, including but not limited to: office notes; lab results; hospital, and other physician records; record of HIV and communicable disease testing; and record of mental health or substance abuse treatment.
- Office notes, labs only.
- Only send the following: \_\_\_\_\_

**Purpose of disclosure** (please check the purpose of the disclosure or check patient request):

- Patient transferring to our care.
- Patient referred to us for treatment of: \_\_\_\_\_
- Other (please specify): \_\_\_\_\_
- Patient Request

**Expirations or termination of authorization:** authorization will expire one (1) year from the date of your signature below, unless you specify an earlier termination. You must submit a new authorization after the expiration date to continue the authorization. You have the right to terminate this authorization at any time. You must notify our privacy manager, in writing, if you decide to terminate the authorization prior to the normal expiration date.

(Please list an earlier expiration if less than one year): \_\_\_\_\_

**Right to revoke or terminate:** As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager.

**Non-Conditioning statement:** The practice places no condition to sign this authorization on the delivery of healthcare or treatment.

**Redisclosure:** 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 will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of the practice.

\_\_\_\_\_  
Patient signature

\_\_\_\_\_  
Copies of signed authorizations are available upon request.

\_\_\_\_\_  
Date

## **Explanation for Limited Patient Authorization**

The Limited Patient Authorization will give our office the authority to provide access to your health information for the person you have listed on the form. The Limited Patient Authorization is limited to accessing your information and does not give any other rights to the person you have named on the form. Use of this form will enable us to provide your health information to person's or entities that may be involved in your healthcare (i.e., family members or friends).

The following information will help to explain what information we will need and the purpose of specific sections of the form.

**Patient Name** - Print your name.

**Social Security Number and Date of Birth** - This information is needed for identity verification and will be maintained in a confidential manner at all times.

### **Purpose of Request**

**Entity Providing Information** - Print the name of our practice or, if you are requesting another healthcare provider to send information to us, the name of another healthcare provider. This simply identifies who will provide the information.

**Entity Receiving the Information** - Print the name and contact information of the person you want to receive or have access to your health information. If you are requesting another healthcare provider to send your health information to us, you would list the name and contact information for our practice.

**Description of Information to be Disclosed** - The type and amount of health information that we disclose is your choice. It can be all of your health information or it can be limited to specific information that you would list on the form.

**Purpose of Disclosure** - Regulations require that we identify the purpose for disclosing limited information (see choices on the form). You also have the right to keep the purpose to yourself by selecting "Patient Request".

**Expiration or Termination** - This authorization will expire at the end of the calendar year in which it was signed unless you specify an earlier termination. The authorization must be renewed each year as a means of protecting your information and verifying your wish to continue the authorization.

**Right to Revoke or Terminate** - You may revoke or terminate this authorization at anytime by contacting our Privacy Manager. Requests for revocation or termination must be made in writing.

**Non-Conditioning Statement** - This simply states that our practice does not place conditions for treatment on the use of this statement.

**Redisclosure Statement** - We cannot be responsible for what your Personal Representative does with your health information that we would provide under this authorization. The redisclosure statement simply informs you of this situation.

**Signature and Date** - We will need your signature and date of the signature to make the authorization effective.

**Copies** - We will provide you with a copy of this signed authorization upon request.

Please address any additional questions with our staff.