

**Standard Authorization of Use and Disclosure of Protected Health Information**

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

**Information to Be Used or Disclosed**

The information covered by this authorization includes:

Complete Record: \_\_\_\_\_ Specific Record: \_\_\_\_\_

Sensitive Information:  Abortion  Abuse  AIDS/ARC  Alcohol Abuse  Hepatitis  Infertility  
 Mental Health Visits  Sexual Abuse/Assault/Rape  Substance Abuse  
 Other (Please Specify) \_\_\_\_\_

**Purposes of Disclosure**

Information listed above will be disclosed for the following purposes:

Leaving WWC  Personal Records  Insurance Company  2<sup>nd</sup> Opinion/Consult/Referral  
 Other (Please Specify) \_\_\_\_\_

**Persons Authorized to Use or Disclose Information**

Information listed above will be **disclosed by**:

Wellesley Women's Care  
Name of person/organization

\_\_\_\_\_  
Name of person/organization

\_\_\_\_\_  
Name of person/organization

**Persons to Whom Information May Be Disclosed**

Information described above may be **disclosed to**:

\_\_\_\_\_  
Name of person/organization

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City/State/Zip Code

**Expiration Date of Authorization**

This authorization is effective through \_\_\_\_ / \_\_\_\_ / \_\_\_\_ unless revoked or terminated by the patient or the patient's personal representative.

**Right to Terminate or Revoke Authorization**

You may revoke or terminate this authorization by submitting a written revocation to **Wellesley Women's Care**. You should contact the **Practice Manager** to terminate this authorization.

**Potential for Re-disclosure**

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. If may not be possible to ensure your right to the protection of the privacy of this information once **Wellesley Women's Care** discloses it to another party.

**Rights of the Individual**

You may inspect or copy information used or disclosed under this authorization. You may refuse to sign this authorization.

**Effect of Refusing Authorization**

If you refuse to sign this authorization, **Wellesley Women's Care** will not deny you any treatment except research-related treatment that you have requested for the purpose of disclosure to others, including:

\_\_\_\_\_  
Treatment conditioned on authorization

\_\_\_\_\_  
Treatment conditioned on authorization

**Signature**

\*

\_\_\_\_\_  
Name of Patient (print or type) **Signature of Patient** **Date**

\_\_\_\_\_  
Signature of Patient Representative

\_\_\_\_\_  
Relationship of Patient Representative to Patient