G# _____

Limited Patient Authorization for Disclosure of Protected Health Information
Please print all information. Form must be signed and dated.

Patient Name Printed: _____

Social Security Number: XXX-XX- __ __ __ __ **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.
Who will provide or disclose information:
Warsaw Women's Center
1275 Provident Drive, Warsaw, IN 46580 Phone: 574-269-4026

Who will be authorized to receive information (family, friends, others):
Minor Patient: Parent/Legal guardian needs to be listed for identification purposes.

Name: _____ Relationship: _____ Phone: ( ) _____

Name: _____ Relationship: _____ Phone: ( ) _____

Name: _____ Relationship: _____ Phone: ( ) _____

Description of the 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:
Minor Patient: Parents automatically have access to all records <u>excluding</u> STD or pregnancy related items (even if the "All records" box is marked below)

- ☐ All records, including every category listed below
- ☐ Office notes, labs and x-rays only
  - ☐ office notes ☐ lab results ☐ x-rays; hospital ☐ pregnancy test results
  - ☐ nursing home, home health, hospice, and other physician records
  - ☐ record of HIV and communicable disease testing, including testing for sexually transmitted diseases
  - ☐ financial history report (previous, 3 years only)
  - ☐ only disclose the following _____

Purpose of disclosure (please check the purpose of the disclosure or check patient request):
☐ Patient Request
☐ Other (please specify): _____

Expirations or termination or authorization: This authorization will expire upon the termination of your physician/patient relationship with a practice of Associated Surgeons & Physicians, unless you specify an earlier termination. 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. 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 _____ **Date** _____

Parent/Legal Guardian Signature_____