Advanced Women's Health
OB/GYN

HIPAA - PRIVACY POLICY

Patient's Name: _____ Date of Birth: _____

This is not a Medical Release Consent Form

The HIPAA Privacy Rule Provides federal protections for individually identifiable health information held by covered entities and their business associates and patients an array of rights with respect to that information. At the same time, the Privacy Rule is balanced so that it permits the disclosure of health information needed for patient care and other important purposes.

Here at Advanced Women's Health, we want to assure the confidentiality, integrity, and availability of electronic protected health information.

I, _____, authorize Advanced Women's Health to disclose any
(Patient Name)
protected health information and give access to my medical records as well as schedule, cancel, reschedule, or confirm appointments on my behalf to the following individuals (i.e., family, friend(s), spouse, etc.):

Name of Individual: _____ Relation/Phone Number: _____

Name of Individual: _____ Relation/Phone Number: _____

Name of Individual: _____ Relation/Phone Number: _____

☐ I DO NOT WISH TO LIST ANYONE ON MY HIPPA FORM

I understand that the information used or disclosed under this authorization form may be subject to change by the person(s) or facility receiving it and would no longer be protected by federal privacy regulations. I have the right to refuse to sign this authorization form. If signed, I have the right to revoke this authorization, in writing, at any time. I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect this actions.

**Please be advised that there are certain circumstances where we are required by law to release medical information. Included but not limited to: other medical facilities (in which the patient has or will be receiving medical services), for billing and insurance purposes, disability, and/or if the state or courts are requesting (subpoenaed).*

I understand that this authorization will expire 1 (one) year from the date below.

_____ Date: _____

Signature of Patient/Guardian