Oncology for Women

A WOMEN'S CARE SPECIALIST
SPECIALIZING IN GYNECOLOGIC ONCOLOGY AND GYNECOLOGY
9100 OLD GEORGETOWN ROAD. BETHESDA, MD 20814
Phone 301.564.4966 ❁ Fax 301.564.9356 ❁ Answering Service 877.629.5732

Individual Patient's Authorization

This form is to confirm your authorization to use or disclose your protected health information for a special purpose.

Psychotherapy Notes: _____ Check here is this authorization is for psychotherapy notes.

If this authorization is for psychotherapy notes, it may not authorize the use or disclosure of any other type of protected heath information.

1. Individual Patient (or Personal Representative) Confirming the Authorization

I give my authorization to use or disclose my protected health information as described in Section 2 below. I give this authorization voluntarily.

Your Name: _____

Your Street Address: _____

Your City: _____ State: _____ Zip: _____

Your eMail: _____

Your Patient Account Number: _____

2. The Use and/or Disclosure Authorized

Describe in detail the protected health information you are authorizing to be used and/or disclosed (if this authorization is for psychotherapy notes, no other type of protected health information may be listed here):

_____

_____

_____

_____

Name the people and/or organizations (or the kinds of people and/or organizations) that you are authorizing to use and/or disclose the protected health information described above.

_____

_____

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Name the people and/or organizations (or the kinds of people and/or organizations) that you are authorizing to receive and use your protected health information.

Describe each purpose for which you are authorizing your protected health information to be used and/or disclosed.

3. Ending This Authorization

Select one of the two choices.

❑ This authorization will end on the following date: _____

❑ This authorization will end when the following event happens. The event must relate to the individual or the purpose of the authorized use and/or disclosure. Describe the event below:

4. Changing Your Mind About This Authorization

I understand that I may revoke this authorization at any time by giving written notice to the Privacy Officer at your office. However, I understand that I may not revoke this authorization for any actions taken before receipt of my written notice to revoke this authorization. In addition, I understand that if I am giving this authorization as a condition of obtaining insurance coverage, and I revoke this authorization, the insurance company has the right to contest my claims under the insurance policy.

5. Signing This Authorization is not a Condition of Treatment

I understand that under most circumstances a healthcare provider may not condition treatment, payment, enrollment, or eligibility for benefits on my signing this authorization. However, I understand that signing an authorization that permits the use and/or disclosure of my protected health information for research purposes may be a condition of my treatment if I am undergoing research-related treatment. Also, I may be required to sign an authorization if my treatment is solely for the purposes of creating protected health information for disclosure to a third party. And under some circumstances, a health plan may condition my enrollment in a health plan or my eligibility for benefits on my providing an authorization permitting the health plan to make enrollment and eligibility determinations.

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6. Possibility of Redisclosure

I understand that information disclosed under this authorization may be redisclosed by the recipient. Federal privacy rules may not protect the privacy of my health information once the recipient rediscloses my health information.

7. Individual Patient's Signature

I have had a chance to read and think about the content of this authorization form and I agree with all statements made in this authorization. I understand that, by signing this form, I am confirming my authorization for use and/or disclosure of the protected health information described in this form with the people and/or organizations named in this form.

Signature: _____ **Date:** _____

If this authorization form is signed by a personal representative for the individual patient:

Personal Representative's Name: _____
Print Name

_____
Signature

Relationship to Patient: _____

You have a right to have a copy of this form after you sign it.

Submit the authorization to the Privacy Official and include a copy in the individual patient's medical record.

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Patient Record of Disclosures

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

❑ Home Telephone _____

❑ OK to leave message with detailed information

❑ Leave message with call-back number only

❑ Work Telephone _____

❑ OK to leave message with detailed information

❑ Leave message with call-back number only

❑ Written Communication

❑ OK to mail to my home address

❑ OK to mail to my work/office address

❑ OK to fax to this number: _____

❑ OK to eMail to this address: _____

❑ Other _____

_____ _____
Patient Signature Date

_____ _____
Print Name Birth Date

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

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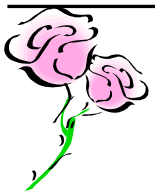

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Record of Disclosures of Protected Health Information

Date	Disclosed To Whom Address or Fax Number	(1)	Description of Disclosure / Purpose of Disclosure	By Whom Disclosed	(2)	(3)

(1) Check the box if the disclosure is authorized
(2) Type key: T = Treatment Records, P = Payment Information, O = Healthcare Operations
(3) Enter how the disclosure was made: F= Fax, E = eMail, M= Mail, O = Other

eMail correspondence may not be HIPAA compliant.