SPECIALISTS IN WOMEN'S HEALTHCARE, P.C.
134 GRANDVIEW AVENUE
WATERBURY, CT. 06708

PATIENT AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Connecticut law, SWHC may not use or disclose your health information without your authorization except as provided in our Notice of Privacy Practices. Your completion of this form gives SWHC permission for the use and disclosure of your information as described below. I understand that I have the right to receive a copy of this authorization if requested.

Refusal to Sign Authorization: I understand that my health care treatment or benefits will not be affected by my refusal to sign this form. I understand that I may revoke this authorization at any time by notifying SWHC in writing as described in the Notice of Privacy Practices. My revocation will not affect actions taken by this medical practice prior to its receipt.

I hereby authorize the practice of ______________________________
(name of practice)

to release health information of : ______________________________
(patient name)

Date of Birth:__________ Soc. Sec.#__________________
(Other names, Maiden name)__________________

Dates of Service to Release:____________OR _____Entire Medical Chart

DESCRIPTION OF INFORMATION TO BE DISCLOSED:______________________________

PLEASE PRINT: Send Medical Records to:

NAME: ______________________ SPECIALISTS IN WOMEN'S HEALTHCARE, P.C.

ADDRESS: ______________________ OR 134 GRANDVIEW AVENUE, SUITE 210

______________________ WATERBURY, CT. 06708 ______________

Restrictions: I understand that the recipient of this information may not use or disclose this information except for the expressed purposes identified above, unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.
I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

EXCLUSION: (Please initial): Drug/Alcohol_____,Mental Health/Psychiatric_____,Sexually Transmitted Disease_____,HIV/AIDS_____,

OTHER: (Specify)______________________________

This authorization is effective this date:______________________thru______________________(MUST BE SPECIFIED)

SIGNATURE:______________________PRINT NAME______________________DATE______________

(Please check)
I am the _____Patient_____Guardian_____Conservator_____Patient's Representative

If this form was completed by someone other than the patient, please print your name and address below:

Name:______________________Address:______________________________