SOUTH COAST
UROGYNECOLOGY

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

_____	_____
Name of Patient	Birth Date
_____	_____
Street Address	City, State, Zip Code
I hereby authorize:	To disclose my protected health information, as described below, to:
_____	_____
Name of individual or entity	Name of individual or entity
_____	_____
Street Address	Street Address
_____	_____
City, State, Zip code	City, State, Zip code

Information to be released:

___Medical history, Examination reports	___Surgical reports	___Prescriptions
___Hospital records including reports	___Consultations	___Drug abuse
___Laboratory reports	___Allergy records	___All records
___ Sexually transmitted Disease	___HIV test results	___X-ray reports

___Other (please specify)_____

*A listing of the statutory exceptions to release of HIV test results without consent is available.

Purpose for need of disclosure:
___At the request of the individual

_____

I understand that the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information might be redisclosed without obtaining my authorization.

I understand that I have the right to:

- **Receive copy of this authorization.**
- **Refuse to sign this authorization** and that treatment, payment, enrollment in a health plan or eligibility for health care benefits may not be contingent on my signing this authorization.
- **Revoke this authorization,** expect to the extent that the person(s) and or organization(s) listed above have already made in reference to this authorization.

I understand that there is a $25.00 copy fee.

This authorization will remain in effect until the following date(s): _____

_____	_____
Signature of patient (or legal representative)	Date

If signed by Legal Representative:

_____	_____
Relationship of patient (authority to act on patient's behalf)	Date