



## 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:

\_\_\_\_\_  
South Coast Urogynecology, Inc.

\_\_\_\_\_  
Name of individual or entity

\_\_\_\_\_  
31852 Coast Highway, Suite 200

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
Laguna Beach, CA 92651

\_\_\_\_\_  
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**, except 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