Premier Gynecology, Inc.

Authorization for Use or Disclosure of Protected Health Information

4256 Fulton Dr. – Ste. B
Canton, OH 44718-2879
(330) 546-0751
FAX (330) 956-5237

I, ____ Date of Birth ____________________________, hereby authorize Premier Gynecology, Inc.:

- ❑ to **disclose** the following personal health information (PHI) to (please print name and address of where/whom PHI is being disclosed to): ____

  ____

  ____

OR:

- ❑ I hereby authorize Premier Gynecology, Inc. to **request** my personal health information from (please print name and address of where/whom PHI being requested from): _______________

  ____

  ____

And send to my physician at Premier Gynecology, Inc. the following:

❑ Medical history and physical examination	❑ Operative reports
❑ Mammography reports	❑ Labs
❑ Breast ultrasound reports	❑ Pap reports
❑ Pelvic ultrasound reports	❑ Pathology reports

❑ Other ____

The minimum necessary of the above checked items of the protected health information will be released and/or received is being used or disclosed for the following purpose(s): _________________

____

This authorization shall be in force and effect until ____
(SPECIFY DATE OR EVENT THAT RELATES TO THE PATIENT OR THE PURPOSE OF THE USE OR DISCLOSURE), at which time this authorization to use or disclose this PHI expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Administrator at Premier Gynecology, Inc. I understand that a revocation is not effective to the extent that Premier Gynecology, Inc. has relied on the use or disclosure of the PHI.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

Premier Gynecology, Inc. will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to:

- Inspect or copy the PHI to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights).
- Refuse to sign this authorization.
- Receive a signed copy of this authorization.

____ ____________________
Signature of Patient or Personal Representative — Date

____ ____________________
Name of Patient or Personal Representative — Witness

____
Description of Personal Representative's Authority

(copy upon request)