AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION
TO
ASSOCIATES IN WOMENS HEALTH, L.L.C.
16910 Marcy Street, Suite 200
Omaha, NE 68118-2704
Phone (402) 697-7200/Fax (402) 697-7282

Nabity / Bossert / Simmons / Pearsall / Evans / Sullivan / Talaska

I, the undersigned, hereby authorize **the "Practice"** listed below, which includes its physicians, officers, employees and agents, to use and disclose my "protected health information" (as those terms are defined in the Privacy Rules of Health Insurance Portability and Accountability Act of 1996) (hereinafter "PHI") as indicated below.

Patient's Name:_____ SSN:_____

Address: _____ Date of Birth:_____

City:_____ State:_____ Zip Code:_____ Phone Number: _____

THE PRACTICE listed below is authorized to *disclose my PHI to Associates in Womens Health, L.L.C. (address and fax number listed above)*
Name/Organization: _____

Address:_____ Phone #:_____

City/State/Zip:_____ Fax #:_____

My PHI that may be used or disclosed by the Practice is as follows:

__X__ **All Medical Records from the last 2 years**

I understand that my express consent is required to release any health care information related to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use.

☒ **I authorize you to release all health information relating to any tests, diagnoses, or treatments for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use.**

I understand that THE PRACTICE is entitled to use and disclose my protected health information without this authorization for treatment, payment and health care operations, and thus this authorization is to grant THE PRACTICE the right to use or disclose my protected health information for the following other purposes: _____
[List above the specific purposes of use or disclosure. "At Patients request" is acceptable if the patient requests only disclosure of PHI to a particular person or entity and patient does not want to state a specific purpose.]

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Privacy Officer at THE PRACTICE'S address listed above. I further understand that such revocation is not effective to the extent that THE PRACTICE has relied on this authorization for the use or disclosure of the protected health information prior to receipt of my revocation or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my protected health information used or disclosed pursuant to this authorization may be disclosed by the recipient, and in the recipient's possession the privacy of such information may no longer be protected by federal or state law.

I understand that THE PRACTICE 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 except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

I understand and acknowledge that the use or disclosure under this authorization may result in direct or indirect remuneration to THE PRACTICE from a third party in the event such use or disclosure is related to marketing or fund-raising by THE PRACTICE.

I understand that this authorization is in effect until: _____ (indicate a date or event that relates to the authorized use or disclosure) or one year from the date it is signed, whichever is shorter, at which time this authorization to use or disclose this protected health information expires.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Personal Representative's Printed Name Relationship to Patient