

Anew Gynecology and Women's Health, P.C.

Authorization for the Use and / or Disclosure of Protected Health Information

Please initial next to each statement that you understand the information and authorize the desired use.

1. ____ My authorization listed below applies to all information contained in my medical chart, including information provided by me, provided by outside entities including other physicians or medical facilities, and information created or generated as a result of the care provided to me in this medical practice.
2. ____ I authorize all direct or leased employees and professional associates of this medical practice.
3. ____ I authorize all medical providers that are contacted or used by this practice in the course of coordinating my care, and all insurance companies or other parties that have responsibility for payment of my services, and any government or state or federal agencies that legally request my information.
4. ____ I authorize the following people to view and obtain my protected health information and to call regarding my health information on my behalf: (list name and relationship)

Name	Relationship
_____	_____
_____	_____
_____	_____

5. ____ I authorize the practice to contact me at work.
6. ____ I authorize the practice to contact me at home.
7. ____ I understand that I have a right to revoke this authorization at any time. My revocation must be in writing, and must be dated with the new date. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization. My revocation will become effective only after it is received in the practice and has been seen by the providers and staff of the practice.
8. ____ I understand that I have a right to inspect and obtain copies of my own protected health information to be used or disclosed, (in accordance with the federal privacy protection regulations found under 45 C.F.R. 164.525)

I certify that I have read the entire document and I have filled out any answers where required.

Signature

Date

Printed Name

Name of Parent/Guardian

Relationship to Patient

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PRIVACY PRACTICES

I understand that this office has done the following things to meet the HIPAA privacy requirements:

- Designated key privacy personnel, including a privacy officer
- Implemented safeguards to protect patient information
- Committed to complying with the documentation requirements of the law
- Developed an internal complaint process, and
- Established and imposed sanctions for policy violations

These practices are designed to achieve compliance with the health insurance portability and accountability act of 1996, (HIPPA) and specifically with the privacy requirements that are to be implemented in all medical offices as of April 14th, 2003.

I acknowledge that I have received a copy of these privacy practices for this medical office.

Signature

Date

Printed Name