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**AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION- AMBULATORY SETTING**

I, \_\_\_\_\_ hereby authorize:

**From:** Women's Health Consultants, PLC  
 46325 West 12 Mile Road, Suite 250  
 Novi, MI 48377  
 Fax- (248) 465-2850

Patient of Dr. \_\_\_\_\_

Its Director or Designee, or Health Information Management/Medical Records Department, to release protected health information, including alcohol and drug abuse records protected under the regulations in Title 42 Code of Federal Regulations, Part 2, if any: behavioral medicine services records, if any, including communications made by me to a social worker or psychologist; and any information regarding communicable diseases and infections as defined by MCLA 333.5131, if any, which includes venereal disease, tuberculosis, HIV, AIDS and ARC, to individuals or organizations listed below, only under the conditions listed below.

**1. Name of person(s) or organization(s), to whom disclosure is to be made:**

**To:** Name \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone number \_\_\_\_\_ Fax \_\_\_\_\_

I understand that my protected health information disclosed under this Authorization may be subject to redisclosure by the individual or organization named above and its privacy will no longer be protected by the law.

**2. The authorized person must place their initial next to the specific type(s) of information to be disclosed.**

- \_\_\_\_\_ Office Records Dates of Service \_\_\_\_\_
- \_\_\_\_\_ Ultrasound Report Dates of Service \_\_\_\_\_
- \_\_\_\_\_ Laboratory Tests Dates of Service \_\_\_\_\_
- \_\_\_\_\_ Mammogram Report (no films) Dates of Service \_\_\_\_\_
- \_\_\_\_\_ Bone Density Records Dates of Service \_\_\_\_\_
- \_\_\_\_\_ Pap Smear Records Dates of Service \_\_\_\_\_
- \_\_\_\_\_ OB Records Dates of Service \_\_\_\_\_
- \_\_\_\_\_ Other- Describe records required and give approximate date(s) of service: \_\_\_\_\_

**3. The purpose and need for such disclosure:**

- \_\_\_ Employers Request
- \_\_\_ Disability Certification
- \_\_\_ Continuation of Care
- \_\_\_ Physician Request
- \_\_\_ Insurance Claim
- \_\_\_ Consultation
- \_\_\_ Social Service
- \_\_\_ Insurance Application
- \_\_\_ School Requirement
- \_\_\_ Worker's Compensation
- \_\_\_ Attorney Inquiry
- \_\_\_ Personal Use
- \_\_\_ Other (specify) \_\_\_\_\_
- \_\_\_ Moving

4. This authorization can be revoked, in writing, at any time except to the extent that information has already been released or disclosed. Any authorization for the release or disclosure of drug and alcohol abuse records shall end when the purpose for the release has been achieved.

5. This authorization will expire automatically when the purpose for the release or disclosure has been achieved or upon 90 days after the date below, whichever is later.

Signature of Patient \_\_\_\_\_ Date \_\_\_\_\_

Birth Date of Patient \_\_\_\_\_ Phone number of Patient \_\_\_\_\_

**Consent of legal guardian, patient advocate or personal representative if patient is incapable or is a minor.**

Signature of guardian, patient advocate, or personal representative \_\_\_\_\_

Relationship \_\_\_\_\_ Phone Number \_\_\_\_\_

Address \_\_\_\_\_

Witness \_\_\_\_\_