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AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION- AMBULATORY SETTING

I, _____ hereby authorize:

From: Physician's Name _____
 Physician's Street Address _____
 City _____ State _____ Zip _____
 Phone number _____ Fax _____

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: Women's Health Consultants, PLC
 46325 West 12 Mile Road, Suite 250
 Novi, MI 48377
 Fax- (248) 465-2850
 Patient of Dr. _____

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:

<input type="checkbox"/> Employers Request	<input type="checkbox"/> Disability Certification	<input type="checkbox"/> Continuation of Care
<input type="checkbox"/> Physician Request	<input type="checkbox"/> Insurance Claim	<input type="checkbox"/> Consultation
<input type="checkbox"/> Social Service	<input type="checkbox"/> Insurance Application	<input type="checkbox"/> School Requirement
<input type="checkbox"/> Worker's Compensation	<input type="checkbox"/> Attorney Inquiry	<input type="checkbox"/> Personal Use
<input type="checkbox"/> Other (specify) _____		<input type="checkbox"/> 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 _____