Aurora
Innovative Healthcare Center for Women

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name _____ Date of Birth _____

By signing this document, I authorize the release of my information:

[ ] To:	Physician:_____	[ ] To:	Karen Allsup, M.D.
[ ] From:	Address:_____	[ ] From:	3303 Rogers Rd. Ste. 100
	City/State:_____		San Antonio, TX. 78251
	Phone:_____		Phone: (210) 547-4700
	Fax:_____		Fax: (210) 455-5355

The following individual identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of service, level of detail to be released, origin of information, etc,):

( ) Complete Health Record ( ) Radiology/Ultrasound Report ( ) Progress Note
( ) Operative Report ( ) Laboratory/Pathology Report ( ) Other

I understand that information in my health record may include information relating to sexually transmitted disease, HIV testing and/or Aids related diagnosis may be contained in the information. I understand that this information may also include reference to psychiatric treatment or treatment for substance abuse.

_____ Yes, I consent to the release of this information
_____No, I do not consent to the release of this information.

PHI

This information will be used or disclosed for the following purpose: _____

If requested by the patient, purpose may be listed as "at the request of the individual." The purpose(s) is/are provided so that I can make an informed decision whether to allow the release of the information.

This authorization will expire on _____(not to exceed 24 months).

The information _____may, _____may not be faxed.

I understand that I have the right to inspect and copy my own protected health information to be used or disclosed under this under this authorization. The Practice will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI. I also understand that I do not have to sign this authorization in order to receive treatment. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPPA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Aurora Innovative Healthcare Center for Women has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at the address above.

Signature of Patient or Legal Guardian _____ Relationship to Patient _____

Printed Name _____ Date Signed _____