AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I authorize _____ to disclose protected health information ("PHI") from the health records of: Patient Name: _____ Address: _____

Phone Number: _____ Patient Medical Record # or Date Of Birth: _____

I authorize PHI from _____[date] to _____ [date] to be disclosed to Dr. Michelle Mulder, OB/Gyn 300 W. White Mountain Blvd Ste. #300D Lakeside, AZ. 85929 **Phone #** 928-367-1444 **Fax #** 928-367-1446

Specific description of the information to be disclosed:	**Specific description of the purposes of the disclosure:**	**I authorize the provider to use or disclose information related to (check all that apply):**
☐ Discharge Summary ☐ History and Physical Exam ☐ Operative Reports ☐ X-ray Reports ☐ Lab Tests ☐ Pathology ☐ Dr. Notes ☐ Other (specify)_____ _____	☐ Continued Patient Care ☐ Workers' Compensation ☐ Insurance Coverage or Payment for Care ☐ Other (specify) _____ _____ _____ **- OR -** ☐ The disclosure is at my (the patient's) request	☐AIDS/HIV and other Communicable Disease ☐ Behavioral Health Care/ Psychiatric Care/ Mental Health Information ☐ Alcohol and/or Drug Abuse Treatment ☐ Genetic Testing Information

I understand that Dr. Mulder will not condition treatment on my signing this authorization. Dr. Mulder will not deny me treatment if I do not wish to sign this form. I may refuse to sign this authorization form.

I also understand that I may revoke this authorization at any time, with some exceptions. For more details on when I can and cannot revoke this authorization, I can read Summit Healthcare's Notice of Privacy Practices.

To revoke my authorization, I must submit a written request to the Medical Records Department. Unless I revoke this authorization earlier, it will expire on the following date, event, or condition: _____.

I understand that, if this information is disclosed to a third party, the information may no longer be protected by the federal privacy regulations and may be re-disclosed by the person or organization that receives the information.

I understand the matters discussed on this form. I release the provider, its employees, officers and directors, medical staff members, and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

_____ _____

Signature of Patient Date

_____ _____

Signature of Legal Representative Relationship to Patient or Description of Authority to Act for Patient

Form filled out by (if other than pt) _____(print name), and verbalized release to patient. _____(signature).

Translation by_____.

☐ Faxed
☐ PHI rec'd
☐ PHI given to pt

Summit Healthcare
Obstetrics & Gynecoloy
Michelle Mulder, M.D.
300 West White Mountain Blvd. Ste #300D
Lakeside, AZ. 85929

File original in patient record.