

WENDOVER OB-GYN & INFERTILITY, INC.

1908 LENDEW STREET

GREENSBORO, NC 27408

www.wendoverobgyn.com

(336) 273-2835 fax (336) 274-4594

PATIENT AUTHORIZATION FOR USE/DISCLOSURE OF
PROTECTED HEALTH INFORMATION

I hereby authorize Wendover OB/GYN and Infertility, Inc. to disclose my individually identifiable health information as described below. I understand that if the person or organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal or state privacy regulations.

PATIENT NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____ PHONE #: _____

Covering the period(s) of health care:

From _____ to _____ OR Complete Medical Record _____

Information to be disclosed:

- Complete written health records(s), including any that may exist concerning
Mental health care of services
AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection
Communicable diseases
Treatment for alcohol and/or drug abuse

The following limited records: _____

This information is to be disclosed to _____ or released from _____ the following individual or entity:

Name: _____ Phone #: _____

Address: _____ Fax #: _____

Purpose of disclosure: _____

- a. This authorization will expire in 90 days from date of authorization.
- b. I understand that I may revoke or discontinue this authorization at any time by notifying the Privacy Officer in writing, but if I do, it will not have any effect on any actions the Practice took before it received the revocation.

Wendover OB/GYN and infertility, Inc., its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Representative

Date

Print Name

Relationship of Representative to Patient

Please describe the Representative's authority to act on behalf of the Patient