rgoa ROCHESTER GYNECOLOGIC AND OBSTETRIC ASSOCIATES, P.C.

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PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name _____Date of Birth_____

1. **Authorization:** By signing this Authorization, I authorize Rochester Gynecologic and Obstetric Associates, P.C. to use, disclose to and/or obtain from the person or entity named below my protected health information described below ("PHI").
Disclose (send) my information to (print full name and address): _____
_____
_____
Obtain my information from (print full name and address): _____
_____
_____

Description of information (specifically describe the information to be used or disclosed, such as dates of service, type of service, level of detail to be released, origin of information, etc.): _____
_____
_____

_____DO release HIV/AIDS and/or sexually transmitted disease-related and/or psychological or psychiatric treatment and/or drug/alcohol abuse or treatment information, if applicable. I understand that this is a dua release inclusive of sensitive medical information, including HIV.
_____DO NOT release the following information_____
_____

2. Purpose: This information will be used or disclosed for the following purpose(s): _____
_____
(If requested by the patient, purpose may be listed as "at the request of the individual.")

_____ I am not transferring my care to this physician/facility.
_____ I am leaving Rochester Gynecologic and Obstetric Associates, P.C. and am transferring my care to this physician/facility. Reason for leaving Practice:
( ) Moving ( ) Insurance Change ( ) Other (specify)_____

3. Limitations: In addition to the above, the following is/are other criteria or limitations that I make regarding this Authorization:
_____
_____

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4. Expiration Date/Event: This Authorization is valid until ___/___/___ or until the following event: (e.g., end of pregnancy, completion of surgery)_____

5. Voluntary Act/Conditioning of Treatment: I expressly acknowledge that this Authorization is voluntary. I do not have to sign this authorization in order to receive treatment from the Practice. In fact, I have the right to refuse to sign this authorization. I understand that treatment provided for research related purposes only or treatment provided solely to create PHI will not be provided if I do not sign this Authorization.

6. Revocation: I understand that this Authorization may be revoked by me at any time, provided that I submit a signed revocation form to the Practice's Privacy Officer. However, any revocation shall not apply to the extent that the Practice has taken action in reliance on this Authorization.

7. Re-disclosure: I understand that the information used or disclosed pursuant to this Authorization may be re-disclosed by the recipient, and that the information will no longer be protected by the Practice or the HIPAA Privacy Rules.

8. Remuneration: I understand that the Practice will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI other than a record copying and/or processing fee.

9. Copy of Authorization: If the Practice has requested this Authorization from me, I understand that the Practice will provide me with a copy of this Authorization once signed by me.

10. Copying Fees: For permanent records transfer, there is a fee of $.75 per page for copying and administrative costs, not to exceed $20.00. A statement will be mailed to you prior to release of your records. Would you like to be notified prior to your records being sent? ___Yes ___No

_____ _____

Name of Individual (Printed) Signature of Individual

_____

Patient's Address (number and street, city, state, zip)

_____

Phone Number

_____ _____

Signature of Personal Representative Relationship

Date Signed _____/_____/_____ Witness: _____

Fax Numbers: White Spruce Office: 585-461-2328 Pittsford-Victor Office: 585-248-9331
Buffalo Road and Brockport Offices: 585-247-4348