Ob/Gyn
Associates of Holland P.C.

Patient's Authorization to Disclose or Release Protected Health Information to Others

Please print all information. Form must be signed and dated each year.

Patient Name: _____ **Phone Number:** _____

SSN (last four digits):_____ **Date of Birth:** _____

Purpose of request (who will be authorized to receive information) - I authorize Ob/Gyn Associates of Holland PC to disclose or provide protected health information about me to the individual(s) listed below.

Who is authorized to discuss or receive my protected health information?

1.

_____

Name **Relationship** **Phone Number**

Description of information to be disclosed - I authorize the practice to disclose the following protected health information about me to the person identified above:

☐ Entire patient record **OR** check **only** those items of the record to be disclosed:

☐ office notes
☐ lab results, pathology reports
☐ x-rays;
☐ financial history report (previous 3 years only).
☐ confirm and reschedule appointment times
☐ nursing home/home health/hospice/other physician records
☐ record of HIV and communicable disease testing
☐ record of mental health or substance abuse treatment
☐ Only the following: _____

2.

_____

Name **Relationship** **Phone Number**

Description of information to be disclosed - I authorize the practice to disclose the following protected health information about me to the person identified above:

☐ Entire patient record **OR** check **only** those items of the record to be disclosed:

☐ office notes
☐ lab results, pathology reports
☐ x-rays;
☐ financial history report (previous 3 years only).
☐ confirm and reschedule appointment times
☐ nursing home/home health/hospice/other physician records
☐ record of HIV and communicable disease testing
☐ record of mental health or substance abuse treatment
☐ Only the following: _____

- This authorization will expire at the end of the calendar year of your last signature below, unless you specify an earlier termination. You must renew or submit a new authorization after the expiration date to continue the authorization. Please list the date of expiration if earlier than the end of the calendar year: _____
- You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.
- The practice places no condition to sign this authorization on the delivery of healthcare or treatment.
- We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of the practice.

☐ **I DO NOT WISH TO HAVE MY PROTECTED HEALTH INFORMATION RELEASED.**

_____ _____

Patient or authorized representative signature **Date (valid for one year from this date)**

South office: 664 Michigan Ave. Holland, MI 49423 **Grand Haven**: 1475 Robbins Rd. Grand Haven, MI 49417
North office: 3290 N Wellness Dr Suite 120 Building D, Holland, MI 49424 **South Haven**: 749 Phillips St. South Haven, MI 49090
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