Women’s Healthcare of Southern Indiana, LLC.

Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize Women’s Healthcare of Southern Indiana, LLC to use and/or disclose certain protected health information about me to:

______________________________	______________________________
Name of Individual	Relationship to Patient
______________________________	______________________________
Name of Individual	Relationship to Patient
______________________________	______________________________
Name of Individual	Relationship to Patient
______________________________	______________________________
Name of Individual	Relationship to Patient

This authorization permits Women’s Healthcare of Southern Indiana, LLC to use and/or disclose the following individually identifiable health information about me :

All_______	Prescriptions_______
Medical Records_____	Lab results_________
Billing_____________	Appointments________

I do not have to sign this authorization in order to receive treatment from Women's Healthcare of Southern Indiana, LLC. 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 HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the practice at: 5300 State Road 64, Ste 103, Georgetown, Indiana 47122.

Signed by: __________________________ Date:_________ ______________________

Signature of Patient or Legal Guardian — Relationship to Patient

______________________________ ______________________________

Print Patient’s Name — Print Name of Legal Guardian, if applicable