# Center for Fetal Medicine and Women's Ultrasound

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## Authorization for Use or Disclosure of Protected Health Information

As required by the Health Information Portability Act of 1996 (HIPAA) and California law, this practice may not use or disclose your individually identifiable health information except as provided in our Notice of Privacy Practices without your authorization. Your completion of this form means that you are giving permission for the uses and disclosure described below. Please review and complete this form carefully. It may be invalid if not fully completed. You may want to ask the person or entity you want to receive your information to complete the sections detailing the information to be released and purpose of the disclosure.

**I hereby authorize the Center for Fetal Medicine and Women's Ultrasound to use and disclose health information concerning**

Patient Name _____

**Health information to be used or disclosed (as follows)**

Any and all health information other than psychotherapy notes may be released, including, but not limited to, mental health records protected by the Lanterman-Petris-Short Act, drug and/or alcohol abuse records, if any, except as specifically provided below.

_____

**Health information may be disclosed to:**

Referring OB/GYN _____

Name of Insurance Company _____

Other (Spouse, Partner, etc.): _____

**The information is used only for the following purposes (e.g., Send report and testing results to my OB) [Note: If you do not want to list the purpose, write down "at the request of the individual"]**

_____

This authorization is in effect until _____ (identify specific date not to exceed one-year from today's date).

*I understand that I may revoke this authorization at any time by notifying the Center for Fetal Medicine and Women's Ultrasound inwriting. My revocation will not affect actions taken by the medical practice prior to its receipt. I understand that, under California Law, that all recipients of health care information are prohibited from re-disclosing it except as required or permitted by law. I am signing this authorization voluntarily and treatment, payment, or my eligibility for benefits will not be affected. A copy of my identification is attached. If completed by a personal representative, legal documentation of sch is attached.*

Patient Signature _____ Date _____