AUTHORIZATION TO DISCLOSE PROTECTED INFORMATION TO WOMEN FOR WOMEN MEDICAL ASSOCIATES, LLC

PATIENT NAME: _____ **Date of Birth: _____**

SS#: _____

I hereby authorize _____ to disclose my health information to:

Women for Women Medical Associates, LLC (WWMA)

102 I Centre Boulevard Marlton NJ 08053

Fax: 856-267-5025

The above-named patient is currently being treated as an outpatient at WWMA and this information is needed as soon as possible for continuing medical care. Please fax the requested information to WWMA at the fax number listed above.

I understand that the information to be disclosed includes my identity, diagnosis and treatment, including ALCOHOL, DRUGS, GENETIC TESTING BEHAVIORAL OR MENTAL HEALTH SERVICES, REPRODUCTIVE RIGHTS, AIDS and HIV, SEXUALLY TRANSMITTED DISEASES, TUBERCULOSIS and other INFECTIOUS DISEASE information, as applicable.

It is my intent that the use of the information furnished is prohibited for any purpose other than stated above and that the recipient is prohibited from disclosing this information to any other party to whom disclosure is not necessary or required for the purpose stated above.

I understand that I have the right to revoke this authorization at any time. I understand that to revoke this authorization, I must do so in writing and present my written revocation to WWMA. I understand that the revocation will not apply to the extent that WWMA has already taken action in reliance on this authorization.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment, payment or enrollment or eligibility in benefits. I understand that I may inspect or obtain a copy of the information to be used or disclosed as provided in 45 CFR Section 164.524.

PATIENT SIGNATURE: _____ Date: _____

If LEGAL REPRESENTATIVE, sign below, state relationship and authority to sign **AND** attach document of authority.

LEGAL REPRESENTATIVE: _____ Date: _____

RELATIONSHIP: _____ Date: _____

WITNESS: _____ Date: _____

WITNESS: _____ Date: _____