ALLEGHENY
Reproductive Health Center
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Authorization for **USE/DISCLOSURE** of Protected Health Information

I hereby authorize _____to release information
(Name of facility, entity, practitioner)

FROM the record of:

Patient Name_____
DOB_____ SS#_____
Address_____
_____
Telephone #_____

Release/Disclose Information **TO**:

_____
Address _____
_____
Telephone #_____
FAX # _____

For the specific purpose of:
Continued Care ____ Personal ____ Legal ____ Other: _____

Method of Release/Disclosure:
Fax ____ Mail ____ Encrypted Email ____ Verbal ____ Patient pick up ____ Email *(see back) ____

Please check **type of record:** ____Inpatient ____Outpatient ____ Emergency ____ Physician office/clinic
Provide date(s) of treatment (approximate, if unknown) _____

The information to be released is:

____ Most recent Pap results	____ History/Physical Examination	____Ultrasound report
____ Discharge summary	____ Operative Report	____ Lab tests
____ Medication Administration	____ Progress Notes	

Other:_____

I **understand** that my authorization is necessary to **obtain or release** my health information and that I may revoke this authorization at any time, in **writing**, except to the extent that ARHC may have already relied upon it in making a use or disclosure. My written revocation will become effective upon ARHC having knowledge of it.

This authorization is **limited** to the **purpose** and to the person listed above and will be in **effect for 90 days** after the date of my signature, unless otherwise specified. This authorization will expire on the following date _____.

Patient signature _____**Date**_____
Witness signature _____**Date**_____

I **understand** that information released by ARHC under this authorization my re-disclosed by the receiving party, and therefore ARHC and its employees have no responsibility or liability as a result of re-disclosure; as such, the released information is no longer protected by the Privacy Rule. I **understand** that ARHC cannot make me sign this authorization as a condition to receive treatment. I **understand** that I am entitled to a completed copy of this Authorization for Use/Disclosure form.

Please initial to confirm you have read the above and fully understand the content. _____

***EMAIL CONSENT**

HIPAA stands for the Health Insurance Portability and Accountability Act, and was passed by the U.S. government in 1996 in order to establish privacy and security protections for health information. Most popular email services (Ex. Gmail, Hotmail, etc.) do not utilize encrypted email. When ARHC sends you an email, or you send us an email, the information that is sent is not encrypted. This means a third party may be able to intercept the information and read it since it is transmitted over the internet. In addition, once the email is received by you, someone may be able to access your email account and read it.

I understand the risks of unencrypted email and do hereby give permission to ARHC to send me personal health information via unencrypted email.

Patient signature _____

Patient email address _____

Date _____