

**Markle & Hinshaw Gynecology**

**AUTHORIZATION FOR USE AND DISCLOSURE OF INFORMATION**

**Section A: Must be completed for all authorizations.**

**I hereby authorize the use or disclosure of my individually identifiable health information as described below.** I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or a health care provider, that organization may also disclose my health information. If this happens, I understand that my information may no longer be protected by federal privacy regulations.

Patient name: \_\_\_\_\_ ID Number: \_\_\_\_\_

Other names under which documents may be filed: \_\_\_\_\_

Persons/Org. authorized to release the information: \_\_\_\_\_

\_\_\_\_\_

Persons/Org. authorized to receive the information: **Markle & Hinshaw Gynecology, 7190 Ellijay Road, Franklin, NC 28734 Phone 828-342-3766 Fax 828 349-**

Specific description of information (including date(s)): \_\_\_\_\_

\_\_\_\_\_

**The patient or the patient’s representative must read and initial the following statements:**

1. I understand that this authorization will expire only when revoked by an authorized party. Initials: \_\_\_\_\_
2. I understand that I may revoke this authorization at any time by notifying Markle & Hinshaw Gynecology in writing. But, if I do revoke this authorization, my revocation will not have an effect on any actions Markle & Hinshaw Gynecology took in reliance upon my authorization before it received my revocation. Initials: \_\_\_\_\_

You may revoke this authorization by signing a Revocation of Authorization form and returning it to Markle & Hinshaw Gynecology. To request a Revocation of Authorization form, you may contact Markle & Hinshaw gynecology, 7190 Ellijay Road, Franklin, NC 28734.

**Section B: Markle & Hinshaw Gynecology requests the authorization for its own use or for another covered entity to disclose information to Markle & Hinshaw Gynecology for treatment, payment or health care operations purposes.**

1. The purpose of the use or disclosure is to facilitate the provision of medical care and to continue care.
2. Markle & Hinshaw Gynecology will not receive direct or indirect compensation in exchange for using or disclosing the information listed above.

**NOTICE TO PATIENT: You or your representative may inspect and/or copy the health information in accordance with Markle & Hinshaw Gynecology’s policies.**

\_\_\_\_\_

**Section C: Must be completed for all authorizations.**

Patient Name: \_\_\_\_\_ Patient Social Security Number: \_\_\_\_\_  
(Please Print)

Patient date of Birth: \_\_\_\_\_

\_\_\_\_\_  
Signature of patient or patient’s representative

\_\_\_\_\_  
Date

Printed name of patient’s representative: \_\_\_\_\_

**Relationship to patient:** \_\_\_\_\_  
**YOU MAY REFUSE TO SIGN THIS AUTHORIZATION.**