

# Markle & Hinshaw Gynecology

## Authorization for Use or Disclosure of Information for Purposes Requested by Physician's Office

I, \_\_\_\_\_, hereby authorize **Markle & Hinshaw Gynecology** to (check those that apply):

use the following protected health information, and/or

disclose the following protected health information to \_\_\_\_\_

[Specifically describe the information to be used or disclosed, including, but not limited to, meaningful descriptors such as date of service, type of service provided, level of detail to be released, origin of information, etc.]

\_\_\_\_\_  
\_\_\_\_\_

This protected health information is being used or disclosed for the following purposes: [List specific purposes here.]

\_\_\_\_\_

This authorization shall be in force and effect until the event that relates to the patient or the purpose of the use or disclosure is over at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Banks Hinshaw, MD at 7190 Ellijay Road, Franklin, NC 28734. I understand that a revocation is not effective to the extent that Markle & Hinshaw Gynecology had previously relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

Markle & Hinshaw Gynecology will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to:

- Inspect or copy the protected health information to be used or disclosed as permitted under state or federal law.
- Refuse to sign this authorization.

The use or disclosure requested under this authorization will not result in direct or indirect remuneration to the Markle & Hinshaw Gynecology from a third party.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Print name of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to patient (or other authority to serve)