E. DANIEL BIGGERSTAFF, III, M.D.

ADVANCED HEALTHCARE FOR WOMEN

Experience. Expertise. Excellence.

Patient Authorization for Use or Disclosure of Protected Health Information

I authorize the release or disclosure of the protected health information as described below:

Name of Patient_____ Date of Birth_____

Name and Address of Person/Organization releasing information:
_____
_____
_____
_____

Name and Address of Person/Organization receiving information:
_____
_____
_____
_____

I authorize the following information to be disclosed:

[ ]Copies of the patient's medical records for the period ___/___/___ to ___/___/___

[ ]Copies of information described below for the period ___/___/___ to ___/___/___
Medical Data/Information as related to:
[ ] Specific condition(s): _____
[ ] Specific professional service(s): _____
[ ] Specific medication(s): _____
[ ] Other: _____

[ ] Other: _____
_____

Purpose(s) of disclosure:
_____
_____

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OVER PLEASE

I am aware of and specifically waive any privilege regarding the following information which may or may not be contained in these records:

- History of acquired immunodeficiency syndrome (AIDS)
- Sexually transmitted disease
- Human immunodeficiency virus (HIV)
- Behavioral health services/psychiatric care
- Treatment for alcohol and/or drug abuse or similar conditions

I understand that there is the potential for redisclosure of the protected health information by the recipient and that Advanced Healthcare for Women assumes no responsibility for the use or misuse by others of my health information disclosed under this authorization. I release Advanced Healthcare for Women from all legal liability that may arise from this authorization.

The patient or the patient's representative may revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization or, if applicable, during a contestability period. In order for the revocation of this authorization to be effective, Advanced Healthcare For Women must receive the revocation in writing. The revocation must include:

- The patient's name, address, and patient number, if applicable,
- The effective date of this authorization, and the recipients of the protected health information according to this authorization,
- The patient's desire to revoke this authorization, and
- The date of the revocation, and the patient's signature.

Advanced Healthcare For Women will accept written revocations of this authorization via:

[X] Certified U.S. mail
[X] Facsimile at this number: 912/355-0979

ALL revocations must be sent to Advanced Healthcare For Women to the attention of the Privacy Officer, and are not effective until received by the Privacy Officer.

This authorization shall expire on _____. After this date, Advanced Healthcare For Women can no longer use or disclose the patient's protected health information without first obtaining a new authorization form.

I fully understand and accept the terms of this authorization.

_____ _____
Patient's Signature Date

If signature is not that of patient, I am acting on behalf of the patient because:_____
_____

_____ _____
Relationship to patient Witness