Wellesley Women's Care, P.C.
2000 Washington Street, Suite 764 Newton, MA 02462
Phone: 617-965-7800 Fax: 617-965-4581

Standard Authorization of Use and Disclosure of Protected Health Information

Patient Name: _____ _____DOB: _____ _____

Information to Be Used or Disclosed
The information covered by this authorization includes:
Complete Record: _____ Specific Record: _____
Sensitive Information: ___Abortion ___Abuse ___AIDS/ARC ___Alcohol Abuse ___Hepatitis ___Infertility
___Mental Health Visits ___Sexual Abuse/Assault/Rape ___Substance Abuse
___Other (Please Specify)_____

Purposes of Disclosure
Information listed above will be disclosed for the following purposes:
___Leaving WWC ___Personal Records ___Insurance Company ___2nd Opinion/Consult/Referral
___Other (Please Specify)_____

Persons Authorized to Use or Disclose Information
Information listed above will be **disclosed by**:

Wellesley Women's Care
Name of person/organization

_____
Name of person/organization

_____
Name of person/organization

Persons to Whom Information May Be Disclosed
Information described above may be **disclosed to:**

_____
Name of person/organization

_____
Street Address

_____
City/State/Zip Code

Expiration Date of Authorization
This authorization is effective through ____ / ____ / ____ unless revoked or terminated by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to **Wellesley Women's Care**. You should contact the **Practice Manager** to terminate this authorization.

Potential for Re-disclosure
Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. If may not be possible to ensure your right to the protection of the privacy of this information once **Wellesley Women's Care** discloses it to another party.

Rights of the Individual
You may inspect or copy information used or disclosed under this authorization. You may refuse to sign this authorization.

Effect of Refusing Authorization
If you refuse to sign this authorization, **Wellesley Women's Care** will not deny you any treatment except research-related treatment that you have requested for the purpose of disclosure to others, including:

_____
Treatment conditioned on authorization

_____
Treatment conditioned on authorization

Signature

_____
Name of Patient (print or type)

*

Signature of Patient **Date**

_____
Signature of Patient Representative

_____
Relationship of Patient Representative to Patient