WWC OB-GYN
Wellesley Women's Care

Wellesley Women's Care, P.C.
2000 Washington Street, Ste. 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/ARD ____Alcohol Abuse ____Hepatitis ____Infertility ____Sexual Abuse/Assault/Rape ____Mental Health Visits ____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) _____
_____
_____
_____

***If you have any suggestions or if there is anything we can do to improve your patient care experience, please let us know in the space provided above.**

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

released:
Wellesley Women's Care, P.C. _____

_____

_____

Persons to Whom Information May be Disclosed
Information described above may be **disclosed to**
Provide the Address or Fax to where you would like your record

_____

_____

_____

_____

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. It 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 other, including:

_____
Treatment conditioned on authorization

_____
Treatment conditioned on authorization

Print Name:

_____
Name of Patient (print or type)

_____
Signature of Patient Representative

Signature:

_____
Signature of the Patient **Date**

_____
Relationship of Patient Representative to Patient