New Start Women's Care

Compassionate~Personalized~Dedicated

Authorization for Use and Disclosure of Protected Health Information

I _____, hereby authorize, New Start Women's Care to use and/or disclose the following protected health information (PHI) to:

_____ Relationship: _____

_____ Relationship: _____

_____ Relationship: _____

I Authorize New Start Women's Care to leave a message regarding my results on the phone number provided.

Yes / No (Circle one) Phone: (_____) _____

This PHI is being use or disclosed for the following purposes:

Providing appointment reminders

Describing or recommending treatment alternatives

Providing health information about health-related benefits and services that may be of interest to the individual soliciting funds to benefit the covered entity

I understand that I have the right to revoke this authorization at any time by submitting a written request and that a revocation is not effective prior to the revocation date. Furthermore, I understand that the information used for disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and may no longer be protected by the federal privacy regulations.

I also understand that I have the right to refuse to sign this authorization and my treatment or eligibility for benefits will not be conditioned upon this authorization.

The use or disclosure requested in this authorization will result in direct or indirect compensation to **New Start Women's Care** from a third party.

This authorization will remain in effect until further notice from patient or legal guardian of patient.

Signature of Patient or Representative/Guardian Date

Printed Name of Patient or Representative/Guardian