Women's Health Horizons
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Patient Authorization to Use or Disclose Protected Health Information

Patient Name: _____ **DOB:** _____

I hereby authorize the use or disclosure of my individually identifiable protected health information by Women's Health Horizons. I specifically authorize any current employee of Women's Health Horizons, or any individual listed below, to disclose my protected health information as described on this form to the person(s)/organization listed below. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulations and may be subject to re-disclosure by the recipient.

Who will be disclosing the information?

[ ] Women's Health Horizons

[ ] Other:
_____

Who will be receiving the information?

[ ] Women's Health Horizons

[ ] Other: _____

Information to be used or disclosed:

[ ] BOTH (non-HIV medical and HIV- related information)
[ ] My HIV-related information
[ ] My non-HIV medical information
[ ] Other: _____

I understand that I retain the right to revoke this authorization at any time, in writing, by mailing such written notification to Women's Health Horizons, 824 Franklin Park Drive, East Syracuse NY 13057. I further understand that a revocation won't have any effect on any actions taken in reliance on this authorization before receipt of the revocation. The written revocation must include:

- The patient's name, date of birth, and address.
- 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, the date of the revocation, and the patient's signature.

This authorization shall expire as of _____.

I understand that Women's Health Horizons will not condition my treatment on whether I provide authorization for requested use or disclosure if to do so would be prohibited by federal or state law. If authorization is to be used for Women's Health Horizons own use, I retain the right to inspect and copy the information to be used or disclosed.

I fully understand and accept the terms of this authorization.

_____ _____
Signature of Patient or Patient's Representative Date

_____ _____
Printed Name of Patient's Representative Relationship

_____
Witness