AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

I *hereby authorize the use or disclosure of my individually identifiable health information as described below*.

PATIENT LAST NAME: _____ FIRST NAME _____ DOB: ___ / ___ / ___ ACCT # _____

for office use only

This form provides authorization to **Elizabeth Wende Breast Care** to use or disclose certain of your personal health information for the purpose(s) described below. It is intended to properly inform you of how this information will be used or disclosed. You should carefully read the information on this form before signing it.

I AUTHORIZE ELIZABETH WENDE BREAST CARE TO DISCLOSE MY PERSONAL MEDICAL INFORMATION TO THE CONTACTS LISTED BELOW:

NAME: _____ RELATIONSHIP TO ME: _____

Please specify the information to be used or disclosed: ☐ Reports ☐ Lab Results ☐ Images

Date range from Month____ / Day____ / Year____ **to** Month____ / Day____ / Year____

Purpose of Information to be Disclosed [If you have requested the use or disclosure of the information but do not, or elect not to, provide a statement of the purpose, the purpose shall be stated as "at the request of the individual"_____

NAME: _____ RELATIONSHIP TO ME: _____

Please specify the information to be used or disclosed: ☐ Reports ☐ Lab Results ☐ Images

Date range from Month____ / Day____ / Year____ **to** Month____ / Day____ / Year____

Purpose of Information to be Disclosed [If you have requested the use or disclosure of the information but do not, or elect not to, provide a statement of the purpose, the purpose shall be stated as "at the request of the individual"_____

The disclosure of any part of the medical record related to genetic test results will require a separate authorization.

PLEASE NOTE: THIS AUTHORIZATION MAY BE REVOKED AT ANY TIME WITH WRITTEN CONSENT FROM THE PATIENT (READ BELOW)

This authorization shall be in force and effect until from the date of my signature below until either I or my authorized representative revokes my consent.

I understand that I have the right to revoke this authorization at any time, in writing, by mailing such written notification to: SHANNON DEMAY at 170 Sawgrass Drive, Rochester, NY 14620 or by sending such written notification to the following email address: sdemay@ewbc.com.

I understand that a revocation is not effective to the extent that THE ELIZABETH WENDE BREAST CARE has taken action in reliance on this authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the law provides the insurer with the right to contest a claim under the policy or to contest the policy itself.

(over)

I understand that THE ELIZABETH WENDE BREAST CARE will not condition my treatment on whether I provide authorization for the requested use or disclosure if to do so would be prohibited by federal or state law. If a reason exists under law for conditioning my treatment on obtaining this authorization, I have been advised of that fact and of the consequences to me of refusing to sign this authorization.

I understand there is the potential for information used or disclosed pursuant to this authorization to be subject to re-disclosure by the recipient if the recipient is not required by law to protect the privacy of the information. I understand that I will receive a copy of this authorization, if signed by me

_____

***Signature** of patient or personal representative*

_____

***Printed name** of patient or personal representative*

Check one to describe the relationship of Legal Representative to Patient *(if applicable):*

☐ Guardian ☐Guardian Advocate ☐ Health Care Surrogate or Proxy

☐ Other personal representative (explain: _____)