



Authorization to Share Personal Protected Information

Camelback Women's Health WILL NOT release information to anyone other than patients without specific authorization to do so. This includes spouses & parents in accordance with state and federal laws.

If you **do not** wish to have ANY information shared with anyone other than yourself, please sign below:

Patient Signature

Date:

However;

If you **do** wish to have information shared, please read the following:

I hereby certify the following people have complete access to the following protected information, which is including, but not limited to: laboratory results, radiology results, physician notes, assessments and opinions, and financial information relating to account status, collection states, and payment history:

Camelback Women's Health may disclose any or all of the above to the following individuals:

Name: _____ Relationship: _____ SS# or DOB _____

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Name: _____ Relationship: _____ SS# or DOB _____

I understand this authorization will be in effect indefinitely unless a specific date is indicated here: _____. I understand this authorization may be revoked AT ANY TIME by me in writing. I understand the office cannot be responsible for information released under this agreement prior to the receipt of the written revocation/cancellation and will not hold the office responsible for such disclosures.

I understand copies of this information will require written authorization by me; or the above party, before copies will be released.

I have read this agreement and understand my personal protected health information may be shared with the individuals I have indicated above.

Patient: _____ Date: _____

Camelback Women's Health Representative _____