



## AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Patient's Name: \_\_\_\_\_

I hereby authorize the use and disclosure of individually identifiable health information relating to me, which is called "Protected Health Information (PHI)" under federal health privacy law, as described below:

Specific description of the information to be used or disclosed including the dates of service(s):

**Any and all medical information relating to patient's current condition.**

Person(s) or class of persons authorized to make the requested use or disclosure:

<b><u>TotalCare For Women</u></b>	
<b>612 Kingsborough Square, Suite 200</b>	<b>813 Independence Blvd., Suite</b>
<b><u>Chesapeake, VA 23320</u></b>	<b><u>Virginia Beach, VA 23455</u></b>
<b><u>Phone: 436-0167 Fax: 436-0236</u></b>	<b><u>Phone: 497-1400 Fax: 407-9350</u></b>

Person(s) or class of persons to whom the use or disclosure may be made:

**Employer:** \_\_\_\_\_ **Fax #:** \_\_\_\_\_ **OK to Fax**

**Disability Insurance Co.:** \_\_\_\_\_ **Fax #:** \_\_\_\_\_ **OK to Fax**

**Insurance Company:** \_\_\_\_\_ **Fax #:** \_\_\_\_\_ **OK to Fax**

Describe the purpose of the requested use or disclosure:

At the request of the individual (patient).

In reference to patient's spouse, Parent, Caretaker or guardian: \_\_\_\_\_  
Individual's Name

**For the purpose of completing LOA (Leave of Absence), FMLA (Family Medical Leave Act), Short Term Disability (STD), Long Term Disability (LTD) Benefits and employment required claim forms.**

This authorization expires on \_\_\_\_\_, or the date the following event occurs:

---

I understand that if the person or entity that receives this information is not a health plan or healthcare provider covered by federal privacy regulations, the released information may be re-disclosed by the recipient and may no longer be protected by federal or state law.

I understand that I may revoke this authorization at any time by notifying **TOTALCARE FOR WOMEN, A Division of MID-ATLANTIC WOMEN'S CARE, PLC** in writing. However, if I choose to do so, I understand that my revocation will not affect any actions taken by **TOTALCARE FOR WOMEN, A Division of MID-ATLANTIC WOMEN'S CARE, PLC** before receiving my revocation.

I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, or enrollment in a health plan or eligibility for benefits.

I understand that **TOTALCAREFORWOMEN, A Division of MID-ATLANTIC WOMEN'S CARE, PLC** may require me to sign an authorization prior to receiving research-related treatment or for treatment solely for the purpose of creating health information for another party.

I understand that the person I am authorizing to use and/or disclose information for marketing purposes will either be directly or indirectly compensated.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Contact Phone No. \_\_\_\_\_

Patient's signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Personal Representative of the Patient**

Personal Representative Name: \_\_\_\_\_

Relationship: (Parent, Guardian, etc). \_\_\_\_\_

Signature : \_\_\_\_\_ Date: \_\_\_\_\_

**Witness:**

Witness: \_\_\_\_\_ Date: \_\_\_\_\_.

**FORM COMPLETION FEES: Payable prior to completion of form:**

Form completion/Faxed or mailed	(per form, not page)	<b>\$ 15.00</b>
Form completion/copy of medical record/Faxed or mailed	(per form, not page)	<b>\$ 15.00</b>
Form completion/pick-up by patient at either office location	(per form, not page)	<b>\$ 6.00</b>
Update(s) to previously completed claim/form	(per form, not page)	<b>\$ 3.00</b>

**Completed Forms to be picked-up from: [ ] Chesapeake Office [ ] Independence Office**