



HEARTLAND WOMEN'S HEALTH CARE, P.C.

**PATIENT AUTHORIZATION FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION**

By signing this authorization, I authorize Heartland Women's Health Care, P.C. to use and/or disclose certain protected health information (PHI) about me to:

This authorization permits Heartland Women's Health Care, P.C. to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

The information will be used or disclosed for the following purpose:

If requested by the patient, purpose may be listed as "at the request of the individual."

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on _____
{Expiration Date or Defined Event}

The Practice will ___ will not ___ receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from Heartland Women's Health Care, P.C. I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at:

**Heartland Women's Health Care, P.C.
NKC HEALTH SERVICES PAVILION
2790 Clay Edwards Drive, Suite 530
North Kansas City, MO 64116**

Patient Name Printed: _____

Guardian Name Printed (if applicable): _____

Patient or Guardian Signature: _____

Date: _____

PATIENT/GUARDIAN TO BE PROVIDED A SIGNED COPY OF AUTHORIZATION