SOMERSET OB/GYN ASSOCIATES, LTD
126 East Church Street Suite 3100
phone 814-445-3535 fax 814-445-3245

Authorization to use or disclose protected health information

I hereby authorize use or disclosure of the named individual's health information as described below:

Patient Name _____ Date of Birth _____ Social Security Number _____

Address (street, city, state, zip code) _____ Telephone Number _____

The following individual or organization is authorized to make the disclosure:

Í Somerset Ob/Gyn Associates, LTD

Í Other (*please specify*) _____

This information may be disclosed to and used by the following individual or organization:

Í Somerset Ob/Gyn Associates, LTD

Í other (*please specify*) _____

Treatment Dates: _____ Purpose of Request: _____

The following information is to be disclosed: (*Please check one box for each item*.)

yes	no		yes	no	
Í	Í	physician notes	Í	Í	Ultrasound Reports
Í	Í	lab results			
Í	Í	pap/pathology reports			
Í	Í	mammography reports			
Í	Í	cardiac studies			
Í	Í	complete record			
Í	Í	other _____			

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

yes	no	
Í	Í	**I agree to the release of sensitive information**.

Redisclosure: I understand that any disclosure of information carries with it the potential for redisclosure and that the information then may not be protected by federal confidentiality rules.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing. I understand that the revocation will not apply to information already released based on this authorization.

Other Rights:

(a) I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied.

(b) I understand that I may inspect or obtain a copy of the information to be used or disclosed.

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event, or condition: (*If I do not specify an expiration date, event, or condition, this authorization will expire in 1 year.)*

Signature of patient or legal representative _____ Date _____

If signed by legal representative, relationship to patient _____