WESTSHORE PRIMARY CARE

HIPAA Compliant Authorization Form

1. MY INFORMATION:

Patient Name:	Address:
Phone: Fax:	City: State: Zip:
Email Address:	Date of Birth: Last 4 SSN#:

2. CUSTODIAN INFO: I hereby give the following entity permission to release my Protected Health Information (PHI):

Name: **Westshore Midwifery Associates**	Address: **29101 Health Campus Drive Suite 250**
Phone: (440) 827-5483 Fax: (440) 827-5453	City: **Westlake** State: **Ohio** Zip:**44145**

3. INFORMATION REQUESTED: I instruct the above entity to release a copy of the following information (Check One):

See Attached Letter for a detailed description of your choices and mark one below:

☐ Option 1 (list date range) _____ ☐ Option 2 ☐ Option 3 Digital Keychain

4. WHERE TO SEND: I am requesting the above designated records be released to the following entity or person:

Name:	Address:
Phone: Fax:	City: State: Zip:

5. FORM & FORMAT OF RECORDS: I request the copies of records be delivered as follows (Check One):

√	Form	Format	Method of Delivery
	Electronic	PDF	*Email the records to:
	Electronic	FAX	Fax the records to the number indicated above
	Electronic	PDF	Download – Email a secure link to:
	Hard Copy	Paper	Mailed to the address indicated above

**Emailed records sent to an unencrypted email address may be viewable by an unauthorized party. By selecting this delivery method you understand and accept the inherent risks of receiving your records via email to the address you specify.*

6. REASON FOR DISCLOSURE: I am requesting my PHI to be disclosed for the following purpose: Continuity of Care

7. SENSITIVE INFORMATION DISCLOSURE: HIV, Behavioral Health, or Drug and Alcohol Abuse/Treatment information within the dates specified above *are to be released through this Authorization* unless otherwise checked below:

DO NOT RELEASE: (Check all that apply) ___ HIV ___Behavioral Health ___ Drug/Alcohol

This Authorization is valid for 90 days. I may revoke this Authorization at any time by mailing or personally delivering a signed, written notice of revocation to the healthcare provider at which this Authorization was executed. Such revocation will be effective upon receipt, except to the extent that the recipient has already taken action in reliance on this Authorization. I am entitled to a copy of this Authorization upon my request. I may not be required to sign this Authorization as a condition to obtaining treatment or payment or my eligibility for benefits. The recipient of this protected health information is prohibited from re-disclosing the information unless the recipient obtains another Authorization from me or unless the disclosure is specifically required or permitted by law. Where permitted, the information I am requesting to be disclosed may sometimes be re-disclosed by the recipient and may no longer be protected by law. I am entitled to notice if my protected health information is used for marketing and results in remuneration to the provider. I hereby acknowledge that I have read and fully understand the above statements as they apply to me.

_____ _____

Signature of Patient Date

_____ _____

Signature of Parent/Guardian or Personal Representative (attach proper documentation) Date