



Tacoma Women's Specialists, P.S.
Obstetrics, Gynecology and Infertility

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Patient Authorization to Use or Disclose Protected Health Care Information

Patient Name: _____ Date of birth: _____
Previous Name: _____

I. My Authorization

You may use or disclose the following health care information (check all that apply):

- All health care information in my medical record
- Health care information in my medical record relating to the following treatment or condition: _____
- Health care information in my medical record for the date(s): _____
- Other (e.g., X-rays, bills), specify date(s): _____

You may use or disclose health care information regarding testing, diagnosis, and treatment for (Check all that apply):

- HIV (AIDS virus) Sexually transmitted diseases
- Psychiatric disorders/mental health Drug and/or alcohol use

You may disclose/obtain (please circle) this health care information to/from (please circle):

Name (or title) and organization or class of persons: _____
Address or fax: _____

Reason(s) for this authorization (check all that apply):

- At my request Continuing Care
- Legal Insurance

This authorization ends:

- on (date): _____
- in 90 days from the date signed

II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, Payment or enrollment). However, I do have to sign an authorization form:

- To take part in a research study or
- To receive health care when the purpose is to create health care information for a third party.

I may revoke this authorization in writing, if I did, it would not affect any actions already taken by Tacoma Women's Specialists based upon this authorization.

Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

I fully understand and accept the terms of this authorization.

Patient or legally authorized individual signature Date

Printed name if signed on behalf of the patient Relationship (parent, legal guardian, ect.)