Authorization for Use and Disclosure of Health Information

Avina Women's Care can contact me with detailed information and leave a message at

Phone #: (_____)_____ Type (cell, home, work): _____

Avina Women's Care has permission to contact and disclose my medical condition and/or treatment with

Name: _____ Relationship: _____ Phone #: (_____)_____

Name: _____ Relationship: _____ Phone #: (_____)_____

I understand that I may request a copy of the information used or disclosed under this authorization.

I understand that if the person or entity who receives my protected health information is not covered by Federal Health Care Privacy regulations, the personal health information disclosed may be re-disclosed to another person or entity and it will no longer be protected by Federal Health Care Privacy rules.

I understand that I may refuse to sign this authorization and that this refusal will not affect my ability to obtain health care treatment from Avina Women's Care, payment for this treatment, my ability to enroll in a health care plan or be eligible for health care plan benefits.

I understand that I have the right to revoke this authorization at any time, in writing, by notifying the Avina Women's Care Privacy Officer.

Patient Name (Printed): _____ Date of Birth: _____ /_____ /_____

Patient Signature: _____ Date: _____

(Parent/Guardian Signature, if applicable)