PATIENT AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION FOR FMLA AND SHORT TERM DISABILITY PAPERWORK

PATIENT NAME: ____ Today's Date: ______________

Other Last Name: ____ Date of Birth: ______________

Instructions: (1) $20.00 fee (2) fill out this Authorization (3) leave paperwork and (4) allow up to 2 weeks.

I understand Jonathan C. Snead, M.D., P.A. d/b/a Alliance Women's Healthcare ("Alliance Women's Healthcare" or "AWH" herein) is authorized by me to use or disclose my Protected Health Information for a purpose (described in this document) other than treatment, payment, or health care operations. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipient(s) of that information.

I specifically authorize Alliance Women's Healthcare or its designated employee(s) to disclose my Protected Health Information as described on this form to the recipients listed below. I understand that when the 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 state or federal privacy regulations. I further understand that I retain the right to revoke this authorization, if done according to the steps set forth below.

I specifically authorize the use or disclosure of any information in my medical record to fill out the paperwork I have provided to AWH from my employer, insurance company, or other agency as listed below to fill out on my behalf. I understand, acknowledge, and consent to the release of my information which may have sensitive information such as genetic testing, HIV, or STI results.

1. **Please disclose the above information to:**
   Name/Entity: ____ Telephone: ____________________
   Address: ____
   City: ____ State: ____________________ Zip: __________
   Fax: ____
   Please: ☐ **Fax** ☐ **Mail or** ☐ **I'll pick up or** ☐ **Other:** ____________________________

   Name/Entity: ____ Telephone: ____________________
   Address: ____
   City: ____ State: ____________________ Zip: __________
   Fax: ____
   Please: ☐ **Fax** ☐ **Mail or** ☐ **I'll pick up or** ☐ **Other:** ____________________________

2. **Purpose(s) for disclosure of the information:** FMLA or Short Term Disability or ____

3. **Right to revocation**. I have a right to revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization. In order for the revocation of this authorization to be effective, Alliance Women's Healthcare must receive the revocation in writing, and the revocation must include:
   a. My name and address,

b. The effective date of this authorization, and the recipients of the Protected Health Information according to this authorization,
c. My desire to revoke this authorization, and
d. The date of the revocation, and my signature.

Alliance Women's Healthcare will accept written revocations of this authorization via:
Certified U.S. mail or Facsimile at this number: 817-741-9663

ALL revocations must be sent to DARLA SNEAD, and are not effective until received by her.

4. **This authorization shall expire on ________________________________.** After this date/event, Alliance Women's Healthcare can no longer use or disclose my Protected Health Information for the above purposes without first obtaining a new authorization form.

5. I fully understand and accept the terms of this authorization. My signature below signifies I understand sensitive medical information, including genetic, HIV, or STI results may be disclosed.

______________________________	______________________________
Signature of Patient or Patient's Representative	**Date**
______________________________	Maiden:_________________________
Name of Patient	
______________________________	______________________________
Name of Representative (if applicable)	**Description of Representative's authority to act for patient**

***CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS**

This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.

FOR OFFICE USE ONLY

☐ Authorization added to the patient's record on/patient dropped off request on: ____________________________.

☐ Authorization verified by __________________________________ (staff signature).

☐ $20.00 fee collected on ______________________

☐ Special Instructions? Notes?

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