Linda C. Evans M.D., L.L.C.

Authorization to Share Medical Information

Patient Name: _____ Chart # _____

HIPAA stands for Health Insurance Portability and Accountability Act. By law, you have the right to strict confidentiality regarding your visit(s) to our office. In order to release any information, including the date or nature of your visit, our office must have your signed consent and specific instructions about the information you would like to have released. Without written consent, our office cannot release or discuss your information with anyone, (parents, guardians, spouse, faculty, staff, coach). You have the right to revoke this authorization at any time. A copy of this authorization will be kept in your health record. The information disclosed under this authorization could be disclosed by a recipient to a third party and would no longer be protected to the same extent as while solely in the possession of our office.

The individual(s) you list below will be required to know the last 4 digits of your Social Security number, as well as your name and date of birth.

Permission is hereby granted to discuss the health information mentioned below with the following persons. (Please provide us with the Name/Date of Birth/Last 4 digits of their Social Security number for the individual(s) listed below): *

Name: _____Date of Birth: _____

Relationship: _____ Last 4 of SSN: _____

I acknowledge I have read and understand my rights to medical information confidentiality and authorize Premiere Women's Center/Dr. Linda Evans MD and staff to discuss health issues regarding: *

❑ Birth Control ❑ Gynecological Issues ❑ Test Results

❑ Appointment Details ❑ Billing Matters

❑ Other:

_____

This authorization is good until: _____

Please restrict and do not disclose the following information. (While all efforts will be made to accommodate "do not disclose" requests, exact adherence cannot be guaranteed.): _____

_____

By signing below, I electronically sign for and authorize your office to speak with the person(s) above about information indicated. I understand and accept that my personal information will no longer be protected.

Signature: _____ Date: _____