Sunshine Women's Care
OB/GYN Services

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HIPAA Privacy and Release of Information Authorization

I hereby authorize SUNSHINE WOMEN'S CARE CLINIC PLLC and its affiliates, employees, and agents, to use and disclose protected health information (e.g., information relating to the diagnosis, treatment, claims payment and health care services provided or to be provided to me and which identifies my name, address, member ID number) for the purpose of helping me to resolve claims and health benefit coverage issues.

I understand that any personal health information or other information release to the person or organization identified above may be subject to re-disclose by such person/organization.

I understand that I have a right to revoke this authorization by providing written notice to the practice, except where we have already made disclosures in reliance on your prior consent. I understand that I have a right to have a copy of this authorization. I also understand that the information used or disclosed pursuant to this authorization may be disclosed by the recipient.

I further understand that I may refuse to sign this authorization knowing that my refusal to sign will affect my eligibility for benefits or enrollment or payment for or coverage of services.

I have been advised of the practice's Privacy Practices, Release of Billing information policy, assignment of benefits policy and grant the practice medication history authority.

By signing this form, I represent that I am the legal representative of the member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the members behalf with respect to this authorization form.

_____	_____	_____
Patient/Guardian Signature	Print Name	Date

_____	_____	_____
Witness	Print Name	Date