

MICHAEL J. WOLPMANN, MD, FACOG, FACS

Board Certified ~ Fellow of the American College of Ob/Gyn
Fellow of the American College of Surgeons

Patient Authorization for Use or Disclosure of Protected Health Information

I authorize the release or disclosure of the protected health information as described below:

Name of Patient: _____ Date of Birth: _____

Name/address of person **releasing** information: _____ Name/address of person **receiving** information: _____

_____ **Michael J. Wolpmann, MD, FACOG, FACS**
333 Tamiami Trail S, Suite 397
Venice, FL, 34285, Fax: 484.5580

I authorize the following information to be disclosed:

- Copies of patient's medical record for the period _____ to _____
- Copies of information described below for the period _____ to _____
 - Specific lab/x-ray: _____
 - Specific condition: _____
 - Other: _____

Purpose(s) of disclosure: _____

I am aware of and specifically waive any privilege regarding the following information which may or may not be contained in these records:

- ❖ History of acquired immunodeficiency syndrome (AIDS)
- ❖ Sexually transmitted disease
- ❖ Human immunodeficiency virus (HIV)
- ❖ Behavioral health services/psychiatric care
- ❖ Treatment for alcohol and/or drug abuse or similar condition

I understand that there is a potential for redisclosure of the protected health information by the recipient and that Bayside Gynecology assumes no responsibility for the use or misuse by other of my health information disclosed under this authorization. I hereby release Bayside Gynecology from all legal liability that may arise from this authorization.

The patient or patient's representative may revoke this authorization in writing. Please see our Privacy Policy for information on how to execute this.

- This authorization shall not expire.
- This authorization shall expire on _____

I fully understand and accept the terms of this authorization:

Patient's Signature: _____ Date: _____

If signature is not that of patient, I am acting on behalf of the patient because: _____

Relationship to patient: _____ Witness: _____