AUTHORIZATION FORM TO DISCLOSE PROTECTED HEALTH INFORMATION TO FAMILY MEMBERS

Effective April 14, 2003, federal privacy law limits the ability of Lindstrom Ob/Gyn to disclose your health information to others, including to your family members. The privacy law requires that every adult patient must give a written authorization before we may disclose your health or medical information to another person, including to family members such as a spouse. If an authorization is not on file, Lindstrom Ob/Gyn can disclose such information **only** to the individual adult patient to whom the information relates.

If you would like to authorize Lindstrom Ob/Gyn to disclose your health and medical information to your family members, then please complete this form. This will authorize Lindstrom Ob/Gyn to disclose information regarding your medical treatment to your family members.

Patient Information (PLEASE PRINT)

_____

Full Name Social Security Number Phone Number

I am the patient and I authorize Lindstrom Ob/Gyn to disclose to the following individual(s):

_____

Name and relationship Name and relationship

_____

Name and relationship Name and relationship

I hereby authorize the use and/or disclosure of my individual identifiable health information as described above. I understand that this authorization is voluntary. I also understand that if the person or organization authorized to receive the information is not a health plan or health care provider, the released information may be further disclosed and may no longer be protected by the federal privacy regulations.

_____

Signature of Individual Authorizing Release of Information Date

____ I DO NOT AUTHORIZE THE RELEASE OF MY HEALTH AND MEDICAL INFORMATION TO ANY FAMILY MEMBERS.

_____

Signature of Individual Declining Release of Information Date

If signed by an individual's authorized representative, describe the representative's authority:

_____ Patient is a minor; I am the patient's parent or legal guardian
_____ I am the Patient's agent, as designated in the member's Durable Power of Attorney for Health Care.
_____ Patient is deceased. I am the patient's surviving spouse or the executor/administrator of the member's estate.
_____ Other (describe) _____

This Authorization expires (1) upon the termination of care at Lindstrom Ob/Gyn (2) as to a person who has authorized disclosure to her spouse, upon the dissolution of marriage, (3) as of one year from the original signature date.

Your Rights:

* You may revoke this Authorization at any time by providing written notice to Lindstrom Ob/Gyn 2204 S. Dobson Rd., Ste. 202, Mesa, AZ, 85202. Your revocation will not affect any actions already taken in reliance on this authorization.
* You are entitled to receive a copy of this authorization upon request.
* You may inspect or copy any information to be used or disclosed under this Authorization.