

Women's Pelvic Surgery Center of Orlando

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Individual Authorization for Use & Disclosure of Protected Health Information

I, _____ voluntarily give my authorization to use or disclose my protected health information (PHI). I authorize Kathy Y. Jones M.D. and the Women's Pelvic Surgery Center of Orlando to disclose or use: ***All office notes regarding my condition and treatment, Lab Work, Radiological Testing, Diagnostic testing, Operative reports, Procedural reports, Medicine /prescription information, all Psychological or psychotherapy reports, Billing Information.***

- To:** My Primary Care Physician PCP
 My Specialist Physician _____ (Cardiologist, Urologist, Neurologist...)
 Insurance Companies and litigators involved in my case
 Hospital and /or Outpatient Centers
 Other entities according to section 3 of the Privacy Practices: _____

I also authorize the release and disclosure of my PHI/medical records to:

- Husband _____ (Name and Date of birth)
 Parent _____ (Name and Date of birth)
 Children _____ (Names and Dates of birth)
 Other _____ (Name and Date of birth, relation)

Please **DO NOT** release or disclose my PHI/medical records to:

This authorization will expire: _____ (Date)

This authorization will be in place without date restriction.

I understand that, by signing this form, I am confirming my authorization for use and/or disclosure of the protected health information described in this form with the people and organizations I have named on this form. I have received the Notice of Privacy Practices and have been provided an opportunity to review it.

Signature: _____ Date: _____

If this authorization form is signed by a personal representative for the individual patient:

Personal Representative's Name Signature

Relationship to Patient: _____

YOU HAVE THE RIGHT TO HAVE A COPY OF THIS FORM AFTER YOU SIGN IT.