

# Sierra Women's Health

## Consent to Disclose Protected Health Information

By signing this authorization, I authorize Sierra Womens Health to disclose protected health information about me to the following individual(s):

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I understand that NO PROTECTED HEALTH INFORMATION (other than as outlined by the Health Insurance Portability and Accountability Act) can be released to anyone, including spouses, parents, other family members, significant others or friends without this authorization. I understand that I have the right to revoke this authorization in writing at any time. However, any disclosure that occurred prior to the date of revocation is not affected.

Please list daytime telephone number(s) at which you prefer to be reached.

\_\_\_\_\_

Can we leave a message regarding your protected health information at the number(s) you have provided above?

- Yes  
 No

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Patient Name: \_\_\_\_\_

**NOTE TO MINORS AND PARENTS:** The health information of minors is protected. Therefore, in order for Sierra Womens Health to disclose any protected health information to parents, we must have written authorization from the minor patient. Minor patients should be aware that claims cannot be submitted to a parents' insurance company without disclosure of protected health information.