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Kevin Bredeman, D.O., F.A.C.O.G.
Brian Stephens, M.D., F.A.C.O.G.
Lisa Graessle, Nurse Practitioner

PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE
PROTECTED HEALTH INFORMATION TO THIRD PARTIES

By signing this authorization, I authorize **Women's Clinic of Jefferson City, PC** to use and/or disclose certain protected health information (PHI) about me to or for the party or parties listed below.

This authorization permits **Women's Clinic of Jefferson City, PC** to use or disclose to _____ the following individually identifiable health information (specifically describe the information to be released, such as date(s) of service, level of detail to be released, origin of information, etc.)

This authorization will expire on _____ .
(Expiration Date or Defined Event)

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that **Women's Clinic of Jefferson City, PC** has acted in reliance upon this authorization. My written revocation must be submitted to **Women's Clinic of Jefferson City, PC** Privacy Officer at 200 St. Mary's Medical Plaza, Suite 102, Jefferson City, MO 65101.

Signature of Patient or Legal Guardian

Relationship to Patient

Patient's Name

Date

Print Name of Patient or Legal Guardian

Effective date of this notice April 14, 2003

THE HEALTH PLAZA AT ST. MARY'S