Physicians for Women Clinics

AUTHORIZATION TO LEAVE VOICEMAIL OR MESSAGE

_____ _____

Patient Name Date of Birth

I hereby authorize medical providers and personnel of the Physicians for Women's clinics to leave a voicemail or message at the designated phone number listed below. I understand this voicemail or message may contain my protected health information.

Voicemail can be left at this phone number: _____

Also, a message for me may be left at this number: _____ with (Relationship) _____ my _____. I understand this message may contain my protected health information.

I understand that certain information cannot be released without specific authorization as required by state or federal law. By initialing the lines below, I authorize the release of the following protected or sensitive information:

_____ Information regarding the patient's diagnosis and treatment for HIV/AIDS
_____ Psychotherapy notes from a Psychiatrist or psychotherapist
_____ Treatment for alcohol or drug abuse reports

This authorization shall be in force and in effect from signed date until (please check one of the boxes):

☐ **_____ at which time this authorization to use or disclose this protected health information expires.**

OR

☐ **Indefinitely - This authorization to use or disclose this protected health information with not expire.**

- I understand that I have the right to revoke this authorization in writing at any time.
- I understand that such revocation is not effective to the extent that the Clinic has relied on the use or disclosure of the protected health information.
- I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- I understand that I have the right to refuse to sign this authorization.

_____ _____

Signature of Patient/Personal Representative Name of Patient/Personal Representative

_____ _____

Date Description of Personal Representative's Authority