



Reason for this authorization (check all that apply):

- At my request                       Check only if practice requests authorization for marketing purposes
- Check only if practice will be paid or get something of value for providing health information
- Other (Please specify):

This authorization ends: (This document does not permit disclosure of health

information created more than 90 days after the date it is signed.)

- Month              Day              Year  
 /  /
- in 90 days from the date signed
- When the following event occurs:

### My Rights:

I understand I do not have to sign this authorization in order to get healthcare benefits (treatment, payment, or enrollment). However, I do have to sign an authorization form:

- To take part in a research study
- To receive healthcare when the purpose is to create healthcare information for a third party.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Lakewood Women's HealthCare based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- Fill out a revocation form. This form is available on our [forms page](#).
- Write a letter to Lakewood Women's HealthCare.

I understand that by clicking the "I agree" box below, I am giving legal consent for disclosure of my healthcare information, as specified in this form. Once healthcare information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

Name of patient or legal guardian      First Name              Last Name  
                                           

Relationship to patient:

I agree to the terms above      Date:      Month              Day              Year  
 /  /

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