Request for Disability

Patient Authorization for Use/Disclosure of Health Care Information

Patient's Name:_____Date of birth: _____
SSN: _____

I request and authorize **West End Ob\Gyn, PC** to release health care information for the purpose of a Medical Leave, Disability or other purpose designated below.

Name of individual or entity to receive the information:

Address: _____City, State: _____ Zip code: _____
This authorization form applies to the following information (be specific):
_____
This protected health information is being used or disclosed for the following purposes:_____

This authorization expires on date or when the following event occurs:

I understand that I have the right to revoke this authorization, in writing, at any time, but that a revocation is not effective to the extent that West End Ob\Gyn PC has relied on my authorization. I understand that to revoke this authorization, written notification should be sent to:

West End Ob\Gyn, PC, 7601 Forest Avenue, Suite 100, Richmond, Virginia 23229

I understand that once West End Ob\Gyn, PC, releases this information the information may be subject to redisclosure by the party receiving the information and may no longer be protected by federal or state law.

Option 1: I understand that Wes End Ob\Gyn, PC not condition my treatment on whether I provide authorization for the requested use or disclosure. Option 2: I understand that the treatment requested from West End Ob\Gyn, PC is conditioned on my signing this authorization because this treatment is for the sole purpose of providing specific information to the party named above.

If applicable, signing this authorization may result in permission for my physician to receive direct or indirect payment to West End Ob\Gyn, PC from a third party based on the use or disclosure of my medical information.

_____
Signature of Patient or Personal Representative
Date: _____
Description of Personal Representative's Authority_____