ALEXANDRIA WOMEN'S CENTER
304 Masonic Dr - Suite 4001 - Alexandria, LA 71301
Phone: 318-443-7222 Fax: (318) 443-7641

RIGHT TO REVOKE AUTHORIZATION

Except to the extent that action has already been taken in reliance on this authorization, the authorization may be revoked at any time by submitting a written notice to _____ at _____. Unless revoked this authorization will expire on the following date, or after the following time period or event _____.

RE-DISCLOSURE

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996.

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE WHO MAY REQUEST DISCLOSURE

I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form. However, if health care services are being provided to me for the purpose of providing information to a third party (e.g. fitness-for-work test), I understand that services may be denied if I do not authorize the release of information related to such health care services to the third-party. I can inspect or copy the protected health information to be used or disclosed.

I hereby release and discharge _____ of any liability and the undersigned will hold _____ harmless for complying with this Authorization.

Signature:_____ **Date:**_____

Description of relationship if not patient:

_____