AUTHORIZATION TO DISCLOSE HEALTH INFORMATION TO FAMILY AND FRIENDS

I hereby authorize Doylestown Women's Health Center, LLC (the "Practice") to release my Patient Information described below to:

[ ] All of my family members
[ ] Spouse
[ ] Mother
[ ] Father
[ ] Children: ____
[ ] Other Family Members: ____________________________________
[ ] The following persons: ____________________________________
[ ] NO ONE
[ ] DO NOT LEAVE MESSAGES

Documents/Information to Be Released:

Purpose of Disclosure (explain or indicate "at the request of the individual"):

I understand that the Health Insurance Portability and Accountability Act of 1996, and its implementing regulations ("HIPAA") govern the terms of this Authorization. I understand that I have the right to revoke this Authorization, at any time prior to the Practice's compliance with the request set forth herein, provided that the revocation is in writing. I further understand that additional information relating to the exceptions to the right to revoke and a description of how I may revoke this Authorization is set forth in the Practice's Notice of Privacy Practices. I understand that any revocation must include my name, address, telephone number, date of this Authorization, and my signature, and that I should send it to:

Doylestown Women's Health Center, LLC
708 Shady Retreat Rd Suite 7
Doylestown, PA 18901
Attention: [Privacy Officer]

I understand that I am not required to sign this Authorization and that the Practice may not condition treatment on my execution of this Authorization.

I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the Recipient listed above and, in that case, will no longer be protected by HIPAA.

This Authorization expires upon [cessation of treatment; release from hospital; birth of child; conclusion of course treatment].

I hereby acknowledge receipt of a copy of this Authorization.

____
Signature of Individual or Personal Representative

____
Description of Personal Representative's Authority

____
Date of Authorization