Name: ______________________________________

MRN: ______________________________________

DOB: ______________________________________

(Label)

Authorization for Disclosure of Protected Health Information

The GW Medical Faculty Associates ("MFA") may not disclose your protected health information ("PHI") without your written authorization, except as provided in our Notice of Privacy Practices.

If you want MFA physicians, employees, and/or representatives ("MFA") to share your PHI with your spouse, other family members, friends, and/or others,, you must authorize that by completing and signing this form.

This form is optional; MFA will not condition providing treatment to you on whether you complete this form.

I, ______________________________________ (print name) hereby authorize MFA to share the types of PHI described below with the following person(s):

______________________	______________	______________________
(Name)	(Relationship)	(Phone #/email)
______________________	______________	______________________
(Name)	(Relationship)	(Phone #/email)

I authorize MFA to disclose the following types of information to the persons listed above (check all that apply):

- ☐ Any and all information
- ☐ Test results (e.g., lab results, x-rays, biopsies, CT Scans, MRIs)
- ☐ Treatment information (e.g., discussions about your health incl. prognosis, planned or current procedures, care options)
- ☐ Information about appointments at MFA or elsewhere (e.g., the date and time of appointment, location, facility where testing or procedure will be done, why the appointment is being made)
- ☐ Billing information (e.g., balance due, insurance issues)
- ☐ Other ____

Right to Revoke: I understand I have the right to revoke this authorization by sending my request in writing to MFA Privacy Officer, 2120 L St. NW, Washington, DC 20037, or PrivacyOfficer@mfa.gwu.edu. I understand that any revocation will not affect actions taken by MFA in reliance on this authorization before receiving the revocation, as stated in MFA's Notice of Privacy Practices.

Expiration Date: If I do not revoke this Authorization, it will remain in effect until ____________. If I do not provide an expiration date, this Authorization will expire10 years after my last treatment by MFA.

Redisclosure: If you authorize MFA to communicate your PHI to anyone, those persons may redisclose the information, and in that case it may no longer be protected.

With my signature I affirm I am greater than 18 years of age and capable of giving consent. I acknowledge and understand that this authorization will be maintained in my medical record and will remain in effect until revoked by me in writing.
I understand that it is my responsibility to notify a representative of MFA if any of the above information changes.

____

Patient Signature/Signature of Patient's Representative (specify authority for patient rep) Date Signed

____

Witness/MFA Representative Date Signed