



**Preventive Women's Health  
Gynecology & Infertility, PLC**

**Mark WM Doering, M.D.**

Gynecology \* Infertility  
Endometriosis \* Menopause  
LEEP \* Hysteroscopy  
Laparoscopy \* Colposcopy  
Endometrial Ablation

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**HIPPA AUTHORIZATION FOR MEDICAL RELEASE FORM**

Pursuant to federal regulations and law pertaining to patient privacy, your physician is required to obtain your authorization for the release of your protected health information in certain circumstances. This document complies with those regulations.

I authorize the use and/or disclosure of my protected health information as follows:

1. Person(s), class of persons or medical practice authorized to disclose my information

\_\_\_\_\_

2. Person(s), class of persons or medical practice authorized to receive my information

\_\_\_\_\_

3. Description of information to be disclosed:

\_\_\_\_\_

4. The information will be used or disclosed for the following purposes (Note: if patient initiates the request, the statement "at the patient's request is sufficient).  
5. I understand that if the person(s) or entity that receives the information is not a health care provider or a health plan covered by federal privacy regulations, the information may be redisclosed and no longer protected by these regulations.  
6. I understand that I may revoke this authorization at any time by notifying Preventive Women's Health, in writing except to the extent that action has been taken in reliance on this authorization.  
7. This authorization expires in 180 days.

\_\_\_\_\_  
Patient's Name (Print)

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Personal Rep (Print)

\_\_\_\_\_  
Personal Rep's Signature

\_\_\_\_\_  
Date

Patient's Date of Birth: \_\_\_\_\_

Patient's SS#: \_\_\_\_\_