AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

This authorization may be used to permit a covered entity (as such term is defined by HIPAA) to use or disclose an individual's protected health information. Individuals completing this form should read the form in its entirety before signing and complete all the sections that apply to their decisions relating to the use or disclosure of their protected health information.

Information regarding <u>patient</u> for whom authorization is made:
Patient's Full Name:_____ Other Name(s) Used: _____
Date of Birth: _____
Address:_____ City:_____ State:____ Zip Code:_____
Phone: (_____)_____
_____

Information regarding person or entity who can receive and use this information:
Name: _____Relation to Patient:_____
Address:_____ City:_____ State:____ Zip Code:_____
Phone: (_____)_____
_____

Specific information to be disclosed:
□ Entire Medical Record (including patient histories, office notes, radiology studies, films, referrals, consults, billing records, insurance records, and records received from other health care providers, future appointments.)

□ **Billing only**
□ **Future Appointments only**
_____

<u>The individual signing this form agrees and acknowledges as follows</u>:
(i) **<u>Voluntary Authorization</u>:** This authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits (as applicable) will not be conditioned upon my signing of this authorization form.
(ii) **<u>Signature Authorization</u>:** I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws.
SIGNATURES:

Patient/Legal Representative: _____ Date: _____

If Legal Representative, relationship to Patient: _____