Authorization to Use or Disclose Protected Health Information

Patient's Name: _____

Address: _____

Date of Birth: _____ Date of Request: _____

As required by the Privacy Regulations, Allergy, Sinus and Asthma Family Health Center may not use or disclose your protected health information, except as provided in our Notice of Privacy Practices, without your authorization.

I hereby authorize this office and any of its employees to use or disclose my Patient Health information to the following person(s), entity(s), or business associates of this office.

_____

Patient Health Information authorized to be disclosed:

_____

_____

For the specific purpose of: (describe in detail)

_____

_____

Effective dates for this authorization: ____/____/____ through ____/____/_____
This authorization will expire at the end of the above period.

I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond this office's control.

I understand I have the right to:

1. Revoke this authorization by sending written notice to this office and the revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of Patient Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.

I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health information.

_____ _____

Signature of Patient or Patient's Authorized Representative *Date*

_____ _____

Authorized Signature of Facility *Date*