



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 provide authorization to use or disclose protected health information, it will not affect my treatment, payment, enrollment in a health plan, or eligibility of benefits.

Signature of Patient or Patient's Authorized Representative

Date

Authorized Signature of Facility

Date