

STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PHI

Information to be Used or Disclosed

The information covered by this authorization includes:

Purpose of the Disclosure: _____

Will this information be used for marketing? Yes ___ No ___

Has this information been previously de-identified? Yes ___ No ___

Persons Authorized to Use or Disclose the Above Information: _____

(Name of person or organization)

Persons to Whom Information May Be Disclosed: _____

(Name of person or organization)

Expiration Date of Authorization

This authorization is effective through (check one) ___/___/___ or NO Expiration, unless revoked or terminated by the patient or the patient’s personal representative.

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to our office. You should contact the HIPAA Compliance Officer to terminate this authorization.

Potential for Re-disclosure

Information that is disclosed under this authorization may be re-disclosed by the person or organization to which it is sent. The privacy of this information may not be protected under the Federal Privacy Rule depending on whom the information is disclosed to.

Our practice will not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs this authorization.

Name of patient (Type/Print)

Signature of Patient

Date

Signature of Patient Representative (if applicable)

Relationship of Patient Representative to Patient (if applicable)