AUTHORIZATION FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION

As part of your healthcare, this practice originates and maintains electronic records describing your health history, symptoms, examinations, test results, diagnoses, treatment, any plans for future care of treatment and payment for the services or treatment we provided. We use this information to:

- Plan your care and treatment
- Communicate with other health professionals or entities who contribute to your healthcare
- Submit your diagnosis and treatment information for payment for the services or treatment provided to you.

"ONLY AS PERMITTED OR REQUIRED BY FEDERAL OR STATE LAW", WE MAY USE YOUR PROTECTED HEATLHCARE INFORMATION TO DO THE FOLLOWING:

- To disclose, as may be necessary, your health information (including HIV/AIDS, drug/alcohol use, and mental health notes) to other healthcare providers and healthcare entities (such as: referrals to or consultation with other healthcare professionals, laboratories, hospitals, etc) or to others as may be required by law or court order concerning your treatment, payment or healthcare.
- To request from other healthcare entities or providers (doctors, dentists, hospitals, labs, imaging centers, etc) specific healthcare information we may need for planning you care and treatment.
- To submit the necessary information for coverage verification, as well as submit the diagnosis and treatment information to your insurance company, other agencies or individuals for payment of our services and treatment provided to you.
- To leave appointment reminders or other minimum necessary information related to your healthcare or payments on your answering machine, mobile voice mail, text, email, regular mail or with a family member.

If you choose, please list by name and relationship the persons with whom we may discuss any and all your protected health care information including medical, psychiatric, drug or alcohol abuse, HIV testing/AIDs information and/or payment information (example spouse, children, close friend):

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

- You may request a copy of our "Notice of Patient Privacy Practices" prior to signing this authorization. You have the right to revoke your consent in writing, except to the extent that the practice has already made disclosures in reliance upon my prior consent.

I fully understand and agree to this authorization and acknowledge the above rights and disclosures.

_____ _____

Signature of Patient or Legal Guardian Date

_____

Print Patient Name and/or Legal Guardian