AUTHORIZATION

** YOU MAY REFUSE TO SIGN THIS AUTHORIZATION **

Purpose: This form is used to confirm the direction of an individual that we use or disclose protected health information for a particular purpose.

SECTION A: The Individual (or the Individual's Personal Representative) confirming the authorization.

I authorize the use and/or disclosure of my protected health information as described in Section B below. I understand that this authorization is voluntary and made to confirm my direction.

I understand that, if the persons or organizations I authorize below to receive and/or use the protected health information described below are not health plans, health care providers or health care clearinghouses subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

Name: ______________________________

Address: ______________________________

Telephone: ____________________ E-mail: ____________________

Patient Number: ____________________ Social Security Number: ____________________

SECTION B: The use and/or disclosure being authorized.

Protected Health Information to Be Used and/or Disclosed: Specifically and meaningfully describe the protected health information you are authorizing be used and/or disclosed (if this authorization is for psychotherapy notes, no other type of protected health information may be listed on this authorization):

Use of information from my medical record while a patient at OVIEDO HEALTHCARE CENTER

and from other practices/facilities as necessary to care for me

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Entities Authorized to Use or Disclose: Name or specifically identify the persons and/or organizations (or the classes of persons and/or organizations), including us, who you are authorizing to make use of and/or to disclose the protected health information described above (primary care physician, specialists, hospitals, etc.:

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Entities Authorized to Receive and Use: Name or specifically describe the persons and/or organizations (or the classes of persons and/or organizations) to whom you are authorizing us to disclose and/or let use the protected health information described above: (family members, non-relatives, guardians, etc.)

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