AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Health Insurance Portability and Accountability (HIPAA)

SECTION A: MUST BE COMPLETED FOR ALL AUTHORIZATIONS

I hereby authorize the use or disclosure of my individually identifiable health information as described below for purposes other than payment, treatment and health care operations. I understand that the information I authorize a person or entity to receive maybe re-disclosed and no longer protected by federal privacy regulations.

PATIENT NAME: ______________________________ **DATE:** ______________________________

I GIVE MY PERMISSION TO DISCUSS MY MEDICAL CARE WITH THE FOLLOWING PEOPLE:

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****Please Note**: If one of your loved ones calls our office and their name does not appear above, we WILL NOT be permitted to share any information pertaining to your treatment and/or condition. However, it is the preference of Dr. Rosen to speak directly to the patient.**
This authorization is valid and will not expire. I understand that it is my responsibility to notify this office if there is any change.

SECTION B: MY RIGHTS

I understand that I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.

I understand that I may revoke this Authorization at any time by notifying Brevard Podiatry in writing. My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon the Authorization.

I have the right to receive a copy of this Authorization.

This Authorization will not expire unless notified in writing, otherwise will remain part of my permanent medical record.

SECTION C: SIGNATURE/DATE

Date: ____________________ Time: ____________________ AM/PM

______________________________________ ______________________________________

Signature of patient or patient's reprehensive Relationship to patient

1/2019