PATIENT AUTHORIZATION FORM

FOR RELEASE OF PROTECTED HEALTH INFORMATION

PLEASE PRINT CLEARLY:

Patient Name: ____

Address: ____

Phone: __________________ Date of Birth: ____________________

I hereby authorize you to use or disclose the specific information described below, only for the purposes and parties also described below.

Description of the specific information to be used or disclosed:

Specific information: all information regarding my medical care and treatment at the RRPG Primary Care, including all records contained in my medical chart.

This information is being requested for the following purpose:

So that my spouse or family members can discuss my medical care and treatment with the doctors at RRPG- Primary Care in my presence, as well l as in my absence.

Release information to: Name of spouse or family members who may be privileged to this information:

_____________________________ _____________________________

This authorization shall remain in effect from the date signed until:

Indefinitely 6 months from the date 1 year from date

I understand that I may inspect or copy the protected health information to be used or disclosed. I may revoke this authorization in writing by contacting your office. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by HIPAA.

I may refuse to sign this authorization and that you will not condition treatment or payment on me providing this authorization (except to the extent that the authorization is for research-related treatment, in which case you may refuse to provide that research-related information).

Patient Name: __________________________ Signature:_______________________________________

Date: ________________________________