PREMIER HEALTH ASSOCIATES, L.L.C.

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

(For use on all requests other than those to be given directly to patient)

Patient Name:
Home Address:

Home Telephone: **Date of Birth:**

SPECIFY INFORMATION TO BE DISCLOSED: _____
_____
_____

Note: If your health information contains any genetic, HIV/AIDS related (i.e., information regarding any HIV related test, infection, illness including AIDS), venereal disease and/or tuberculosis information, you must specifically mention "genetic information," "HIV/AIDS related information," "venereal disease information," and/or "tuberculosis information" if you want the Practice to disclose such information to any person other than you or your personal representative.

RECIPIENT: Name of person or class of persons to whom the Practice may disclose my health information:
_____
Address of the recipient or where my health information should be delivered:_____
_____

TERM: This Authorization will remain in effect:
From the date of this Authorization until the _____ day of _____, 20 ____.
Until the following event occurs: _____
Other:_____

By my signature below, I hereby authorize the Practice to use or disclose to the recipient my health information for the term of this Authorization for the following specific purpose(s): ("At the request of the patient" is sufficient if the patient is initiating this Authorization):
_____
_____

I understand that once the Practice discloses my health information to the recipient, the Practice cannot guarantee that the recipient will not re-disclose my health information to a third party. Any such third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of the Practice's treatment of me; except, however, if my treatment at the Practice is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case the Practice may refuse to treat me if I do not sign this Authorization.

I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to the Practice. The revocation will be effective immediately upon the Practice's receipt of my written notice, except that the revocation will not have any effect on any action taken by the Practice in reliance on this Authorization before it received my written notice of revocation.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily, authorize the Practice to use or disclose my health information in the manner described above.

_____ _____
SIGNATURE OF PATIENT **DATE**

REFUSED: _____ _____
SIGNATURE OF PATIENT **DATE**

ACKNOWLEDGEMENT OF RECEIPT OF PREMIER HEALTH ASSOCIATES, L.L.C. PRIVACY PRACTICES

DATE: _____

NAME OF PATIENT:

By signing below I hereby acknowledge receipt of Premier Health Associates, L.L.C. Privacy Practices Policy.

Signed: _____
Patient or Legal Guardian

This document is to be retained in patient chart.