AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

This form is used to authorize the release of protected health information in accordance with the Privacy Rule of the Health Insurance Portability and Accountability At of 1996 (HIPAA).

Completion of this document authorizes the disclosure and/or use of health information about you. Failure to provide all information requested may invalidate this authorization.

PATIENT NAME: Last, First Middle Initial _____ DATE of BIRTH _____ SOCIAL SECURITY NUMBER _____

PREVIOUS NAME (Married, Single, etc.) _____ PREVIOUS NAME (Married, Single, etc.) _____

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize **John F. Flory, MD** to release my protected health information to:

PERSON/ORGANIZATION _____ ADDRESS _____

CITY _____ STATE _____ ZIP _____

TELEPHONE _____ FAX _____ EMAIL * Must have email Address for large records _____

The following information is to be released:

[ ] Entire Record - Date(s) of Service:* _____

*The entire record may at times include HIV test results, alcohol and drug information, genetic testing information, etc

[ ] Office Notes - Date(s) of Service: _____

[ ] Surgical Reports - Date(s) of Service: _____

[ ] Implant Information - Date(s) of Service: _____

[ ] Other (please specify needed information and date(s) of Service: _____

_____

Patient's Initials

_____ I understand that the information in my medical records may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse. I understand that by signing this authorization, I am authorizing the release of such information unless specified otherwise above.

_____ I understand my treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

_____ This authorization remains valid for two years from the date of signature.

_____ Any facsimile, copy, or photocopy of this authorization shall authorize you to release the records requested herein.

PURPOSE:

The purpose of the release of this information is:

[ ] Insurance or other third-party reimbursement
[ ] Continuity of Medical Care
[ ] Pending legal action
[ ] At the request of the patient
[ ] Other: (Specify) _____

RESTRICTIONS:

I understand that if the person or entity who receives the information is not a health care provider or a health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing substance abuse under the Federal Substance Abuse Confidentiality Requirements.

I realize that the office and its employees have a responsibility to maintain the confidentiality of the medical records in its possession. I understand that once the information is disclosed it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations. The office will not be held responsible for any subsequent disclosure by the recipient of the health information. I release John F. Flory, M.D., and employees of any liability that may arise as a result of any subsequent disclosure of my health information by the recipient.

MY RIGHTS

I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.

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

I may revoke this authorization at any time, but I must do so in writing and submitted to the following address:

John F. Flory, M.D.
PO Box 1657
Powell, OH 43065-1657

My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.

I have a right to receive a copy of this authorization.

Information disclosed pursuant to this authorization could be redisclosed by the recipient.

SIGNATURE

Date: _____ Time: _____am/pm

_____

SIGNATURE LEGAL RELATIONSHIP TO THE PATIENT: Patient / Spouse / Parent / Financially Responsible Party
(please circle)

_____

WITNESS