PATIENT AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize or disclosure of my individually identifiable health information as described below, I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider; the release information may no longer be protected by federal privacy regulations.

Patient name: _____ Date of Birth: _____

Persons/Organizations providing the information

_____

_____

_____

_____

Sending/ Receiving:

Pell City Internal and Family Medicine
Dr. Rick Jotani Dr. Barry Collins Dr. Ilinca Prisacaru

7067 Veterans Parkway, Suite 200

Pell City, Alabama 35125

Phone (205) 884-9000 Fax (205) 884-8111

Specific description of information (including patient demographics and dates of treatment/office visits)

- All medical records and office notes from the last 3 years (including HIV/AIDS, STDs, mental illness records and alcohol and/or drug abuse).
- Other:_____

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Privacy Officer at 7067 Veterans Parkway Suite 200, Pell City, Alabama 35125.
I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information, or if my authorization was obtaining insurance coverage and the insurer has a legal right to contest a claim.

Pell City Internal & Family Medicine will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

I understand I have the right to:

- Inspect or copy the health information to be used or disclosed as permitted under the law
- Refuse to sign the authorization

The use or disclosure requested under this authorization may result in financial gain to my physician from a third party.

This authorization will expire on _____. After this date Pell City Internal & Family Medicine can no longer disclose the patient's protected health information without first obtaining a new authorization form.

I fully understand and accept the terms of this authorization.

_____ _____

Signature of patient or patient's representative **Date**

Printed name of patient's representative: _____

Relationship to the patient: _____