HIPAA CONSENT

PATIENT AUTHORIZATION FOR USE & DISCLOSURE OF PHI WITH CONDITIONS

Patient Name: _____ DOB: _____

I hereby authorize the use or disclosure of my personal health information as described below. I understand the information I authorize a person or entity to receive may be re-disclosed and is no longer protected by federal regulations.

1. Persons within the physician's practice authorized to use or make disclosure of the information: **ALL EMPLOYEES OF Phoenician Medical Center Group of Companies**

2. Persons or organizations authorized to receive the information:

   Spouse Yes No If yes, list person (s) name: _____

   Parent Yes No If yes, list person (s) name: _____

   Other individual, i.e., boyfriend/girlfriend, brother, sister, etc. Yes No

   If yes, please list name (s) and relation: _____

3. Specific description of information that may be used or disclosed: e.g.: **Contact information Tests results, referrals, prescriptions, paperwork, pertinent medical record**

4. The information will be used/disclosed for the following purposes:

   A. To inform me of my medical condition (s) by phone, mail, email or in person.

   B. To give information/referrals/medical records/samples/prescription, paperwork, and or test results to you or the person (s) named on this form, by phone, mail email or in person.

   C. For treatment, payment and health care operations.

5. This authorization expires on: _____.

   I understand that I may revoke this authorization at any time by notifying the physician's office providing the information in writing. However, the revocation will not be valid, if:

   A. The physician has taken action in reliance of this authorization, or

   B. If this authorization is obtained as a condition for obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

Signature of Patient or Representative: _____ Date: _____

Printed Name of Patient or Patient's Representatives: _____