

Patient Authorization to Use or Disclose Protected Health Information

I, _____, understand Dr. David R. Chapman and Dr. Brent J. Baroody are authorized by me to use or disclose my protected health information for a purpose other than treatment, payment, or health care operations. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipient(s) of that information. I specifically authorize any current employee of Dr. David R. Chapman and Dr. Brent J. Baroody, or any other individual listed below to disclose my protected health information as described on this form to the recipients listed below. I further understand that I retain the right to revoke this authorization, if done so according to the steps set forth below.

Describe the information to be used or disclosed (*check all that apply*):

- The patient's entire medical record
(NOTE: This requires an explanation why the entire record may be disclosed).

- The patient's demographic information (*check all that apply*)
 - Name Address State/Zip Code only Telephone
 - Age Gender Race Other: _____

- Medical Data/Information as related to:
 - Specific condition(s): _____
 - Specific professional service(s): _____
 - Specific medication(s): _____
 - Other: _____

To whom and where is the patient's health information to be sent:

Purpose(s) of the information:

(Check if applicable) This authorization is to be used for our own use, and Dr. David R. Chapman and Dr. Brent J. Baroody will not condition treatment or payment on this authorization. Moreover, the patient has a right to inspect or copy the information to be used or disclosed and may refuse to sign this authorization.

(Check if applicable) The patient understands that Dr. David R. Chapman and Dr. Brent J. Baroody may receive financial gain as a result of disclosing this information due to _____.

(Check if applicable) This authorization permits Dr. David R. Chapman and Dr. Brent J. Baroody to send the protected health information ONLY to this address or fax number:

Any other address or fax number is not permitted by this authorization

The patient has a right to revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization or, if applicable, during a contestability period. In order for the revocation of this authorization to be effective, Dr. David R. Chapman and Dr. Brent J. Baroody must receive the revocation in writing. The revocation must include:

- The patient's name, address, and patient number, if applicable,
- The effective date of this authorization, and the recipients of the protected health information according to this authorization,
- The patient's desire to revoke this authorization, and
- The date of revocation, and the patient's signature.

Dr. David R. Chapman and Dr. Brent J. Baroody will accept written revocations of this authorization via:

- Certified U.S. Mail
 Facsimile at this number _____

ALL revocation must be sent to Dr. David R. Chapman and Dr. Brent J. Baroody to the attention of the Privacy Officer, and are not effective until received by the Privacy Officer.

This authorization shall expire on _____. After this date, Dr. David R. Chapman and Dr. Brent J. Baroody can no longer use or disclose the patient's protected health information without first obtaining a new authorization form.

I fully understand and accept the terms of this authorization.

Patient's Signature

Date

FOR OFFICE USE ONLY

Authorization added to the patient's medical record on _____.

Authorization verified by _____ on _____.