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Authorization for the Use and Disclosure of Protected Health Information

As required by Health Insurance Portability and Accountability Act of 1996, Radiantly Healthy MD may not use or disclose your health information except as provided in our Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures of protected health information described herein. You may revoke this authorization at any time by signing and dating the revocation section on your copy of the form and returning it to this office.

Patient Name: _____ **Date of Birth:** _____

Authorization Section

I authorize the following person(s) to receive information regarding my health care:

Name: _____

Name: _____

Leave messages on answering machine: ___ Yes _____ No

Leave messages on cell phone: _____ Yes _____ No

I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer protected.

I understand that I may revoke this authorization at any time by signing the revocation section of my copy of this form and returning it to Radiantly Healthy MD. I further understand that such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this authorization.

I understand that this authorization will automatically expire _____ (Expiration date or expiration event, such as termination of coverage). If I do not specify an expiration date, event or condition, this authorization will expire in one year.

I understand that I am under no obligation to sign this authorization. I understand that Radiantly Healthy MD may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization or not.

I understand that I have a right to inspect and to obtain a copy of any information disclosed pursuant to this authorization.

Signature: _____ **Date:** _____

Print Name: _____ **Telephone:** _____

If not signed by the patient, please indicate relationship of signee:

_____ Parent or Guardian _____ Guardian or Conservator of an Incompetent

_____ Beneficiary or personal representative of deceased

_____ Other (specify)

I have also read and understand the Florida Malpractice Flyer

Signature

Date

Revocation Section

I hereby revoke this authorization:

Signature

Date