RH MD
RADIANTLY HEALTHY

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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