AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize the use and/or disclosure of health information about me as described below.

Patient Name: _____

Patient's Date of Birth: _____ Patient's SSN: _____

A. Person(s) or organization(s) authorized to provide or release the information:

_____

_____

B. Person(s) or organization(s) authorized to receive the information:

_____

_____

C. Specific description of the information to be used or disclosed (including date(s) of information)

_____

_____

_____

_____

D. Specific description of how the information will be used: _____

_____

_____

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1) I understand that this authorization will **expire** on _____ *(insert date)*.

2) I understand that I may **revoke** this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying Southeast Physician Network, P.C. in writing at 1410 McFarland Blvd. North, Tuscaloosa, Alabama 35406.

3) I understand that I can **refuse to sign** this authorization and that my refusal will not affect my ability to obtain treatment, payment, or my eligibility for benefits (if applicable).

4) I may **inspect or copy** any information used or disclosed under this authorization.

5) I understand that if the person or organization that receives the information is not a health care provider or plan covered by federal privacy regulations, the information described above may be redisclosed and would no longer be protected by the regulations under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

_____ _____

Patient's Signature or Patient's Representative Date

_____ _____

Printed Name of Patient's Representative (*If applicable*) Relationship to Patient

(If individual is signing as the patient's representative we must be provided with legal documentation of that representation)

YOU HAVE THE RIGHT TO RECEIVE A COPY OF THIS FORM