PATIENT AUTHORIZATION TO USE OR DISCLOSE
PROTECTED HEALTH INFORMATION

I, _____, understand that HILDEBRAN MEDICAL CLINIC is authorized by me to use or disclose my protected health information for no other purpose than treatment, payment, or health care operations. Our office will only release patient information to other physicians that may be treating a patient for health concerns. 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 or owner of HILDEBRAN MEDICAL CLINIC or any other individual listed below, to disclose my protected health information as described on this form to the recipients listed below. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information. *I further understand that I retain the right to revoke this authorization, if done so according to the steps set forth.*

Description of the information to be used or disclosed:

The patient's entire medical record, i.e. name, address, telephone, age, gender, race etc.

Person(s) that our office is allowed to discuss your medical information with (other than a physician(s) for treatment of care):

_____

Hildebran Medical Clinic is constantly sending and faxing patient information related to patient treatment. Our office requests the patients consent, not to keep a log of every individual, company, pharmacy, physician etc. that the patient health information is sent to:

Agree
Disagree

When we call your home and you are not available, is it okay to leave a message on your answering machine as to what we are calling about? If you do not agree we will leave a message with our telephone contact information.

Agree
Disagree

The patient has a right to revoke this authorization in writing at any time. The revocation must be in writing to include; patient's name, address, and social security number, the effective date of this authorization, and patient signature.

If you believe your privacy rights have been violated, you may file a complaint with the Secretary of the Department of Health and Human Services, or our Privacy Officer. All complaints must be submitted in writing. You will not be retaliated against for filing such a complaint.

This authorization will remain in effect as long as the patient comes to our clinic. Once the patient terminates their association with our practice, HILDEBRAN MEDICAL CLINIC can no longer use or disclose the patient's protected health information without first obtaining a new authorization form.
I have received a copy of the patient privacy notification for my records

I fully understand and accept the terms of this authorization.

_____ _____

(Patient's Signature) **(Date)**