

MedHelp, PC
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Birmingham, Alabama 35242
(205) 408-1231

Patient Authorization for Use and/or Disclosure of Protected Health Information

Patient Name:		Date of Birth:	
Social Security Number:		Account Number:	
Address:			

I hereby authorize MedHelp to use, disclose and/or obtain my health information as follows (*check all that apply*):

use the following health information maintained by MedHelp until:

_____ Date

disclose the following health information to:

_____ Address: _____

_____ City, State, Zip _____

_____ Phone: () _____

obtain the following health information from:

_____ Address: _____

_____ _____

Specific description of the health information to be used/disclosed/obtained (*include dates of service, i.e., appointment date, type of service, etc*):

_____ This health information is used/disclosed/obtained for the following purpose (*if Authorization requested by the patient put: "At the request of the individual"*):

By providing this Authorization, I understand as follows:

1. I understand that this Authorization is voluntary. I may refuse to sign this Authorization and my treatment and/or payment obligations will not be affected.
2. I understand that the health information to be released may be subject to redisclosure by the recipient of the health information and no longer protected by the federal Privacy Rules.
3. I understand that I may revoke this Authorization at any time by notifying MedHelp in writing, but if I do, it will not have any effect on uses or disclosures prior to the receipt of the revocation.
4. I understand that I will receive a copy of this Authorization form after I sign it.

WHEN THIS AUTHORIZATION COVERS X-RAYS TO BE LOANED TO ANOTHER PHYSICIAN'S OFFICE THE INFORMATION LISTED IN BOLD MUST BE PROVIDED.

Signature of Patient or Patient's Representative

Date:

Printed Name of Patient's Representative (*if applicable*)

Representative's Relationship to Patient (*if applicable*)