WATERFORD FAMILY PHYSICIANS

Authorization of Use and Disclosure of Protected Health Information

(1) Appointment Reminders. Our office may remind you of upcoming appointments by giving you an appointment card at the end of your visit, send you a reminder through the mail, and call your home and/or work. If you have an answering machine we may also leave a message regarding treatment, appointments and/or other information pertinent to your healthcare provided in our office. If you DO NOT wish to use any of these methods, please indicate which one you do not wish for us to use on the following line:

____

(2) Persons Authorized to Receive Information:
Health information (Waterford Family Physicians) collects or receives about you may be disclosed to the following persons. Example: spouse, children, friends, relatives, organization etc.

____ **PLEASE CHECK ONE AUTHORIZATION BELOW**
Name of person / relation / organization

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Name of person / relation / organization

AUTHORIZATION FOR USE AND DISCLOSURE OF INFORMATION: PLEASE CHECK ONE:

_____I authorize the person (s) listed **ABOVE** to receive all health information about appointments, treatment and/or other information pertinent to my healthcare and/or payment for my healthcare provided at Waterford Family Physicians.

____ I **DO NOT** authorize the following information to be disclosed to any other parties except to me as the patient (Please specify what information you do not want disclosed)

(3) Other Uses and Disclosures: Disclosure of your health information or its use for any purpose other than those listed in the "Notice of Privacy Policies and Practices" brochure and/or consent requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision. You have the right to request restrictions on use and disclosure of your health information.

___ I would like the following restrictions regarding the use and disclosure of my health information:

____
____
____

Expiration Date of Authorization
This authorization is effective immediately unless revoked or terminated by the patient or patient's personal representative.

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Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to Waterford Family Physicians. You should contact the PRIV ACY OFFICIAL or other authorized representative to terminate this authorization

Potential for Re-disclosure

The person or organization to which health information is sent may repeatedly disclose health information that is identified by this authorization. The privacy of this information may not be protected under the federal privacy regulations.

I hereby acknowledge that I have received a copy of the H.I.P.A.A. law policy per my signature.

Signature

____
Name of Patient (Print or Type)

____
Signature of Patient / Date

____
Signature of Patient Representative

____
Relationship of Patient Representative to Patient