AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I AUTHORIZE THE USE / DISCLOSURE OF HEALTH INFORMATION ABOUT ME AS DESCRIBED BELOW.

Patient's Name:

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

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

COUNTRYSIDE MEDICAL

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

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

ANY VERBAL OR WRITTEN INFORMATION

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

TO AIDE IN HEALTHCARE

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1) I understand that this authorization will expire on_____
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 Countryside Medical in writing.
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 agreement.
5) I understand that if the person or organization that receives the information is not a health care provider or pain covered by federal privacy regulations, the information described above may be redisclosed and would no longer be protected by these regulations.

_____ _____

Patient's Signature or Patient's Representative Date

_____ _____

Printed Name of Patient's Representative Relationship to Patient

NOTE:
You have the right to know specifically what information you are authorizing for release (e.g. "results of a lab test performed on 1/4/03" or, if your entire medical record is included, "all health information").
You have the right to know the name(s) or other identification of the person(s) or organization(s) authorized to release the information (e.g. the names of your health care provider(s)).
You have the right to know who is going to use it and what it is going to be used for (e.g. John Smith, PhD / Research).

YOU HAVE THE RIGHT TO RECEIVE A COPY OF THIS FORM

HIPAA Authorization for Release of Information
This form does not constitute legal advice and covers only federal, not state laws.