INDIVIDUAL PATIENT'S AUTHORIZATION

1. INDIVIDUAL PATIENT (OR PERSONAL REPRESENTATIVE) CONFIRMING THE AUTHORIZATION

I give my authorization to use or disclose my protected health information as described in Section 2 below. I give this authorization voluntarily.

Your Name ______________________________

Your Street Address ______________________________

Your City ____________________ State ____________ Zip ____________

Your Telephone Number ______________________________

Your E-Mail Address ______________________________

Your Cell Phone Number ______________________________

2. THE USE AND/OR DISCLOSURE AUTHORIZED

Name the people and/or organizations (or the kinds of people and/or organizations) that you are authorizing to use and/or to disclose the protected health information described above.

Union Internal Medicine Group

Name the people and/or organizations (or the kinds of people and/or organizations) that you are authorizing to receive and use your protected health information. (Family Member or Friend)

____

Describe each purpose for which you are authorizing your protected health information to be used and/or disclosed.

Health Care

I have had the chance to read and think about the content of this authorization form and I agree with all statements made in this authorization. I understand that, by signing this form, I am confirming my authorization for use and/or disclosure of the protected health information described in this form with the people and/or organizations named in this form.

Signature: ______________________________ Date: ____________________

If this authorization form is signed by a personal representative for the individual patient:

Personal Representative's Name: ______________________________
Print name

____
Signature

Relationship to Individual Patient: ______________________________

YOU HAVE A RIGHT TO HAVE A COPY OF THIS FORM AFTER YOU SIGN IT.

Submit the authorization to the Privacy Official and include a copy in the individual patient's medical record.