DAVID GREEN, M.D., P.A.

AUTHORIZATION FORM
For Use and Disclosure of Protected Health Information

Federal rules that went into effect in 2003, as part of the HIPAA legistation, mandate that this Authorization Form be provided to you.

This form authorizes Dr. Green to communicate with, or release information to, entities that you specifically designate regarding your healthcare. For example, this may include health insurance carriers (for any claims that you submit for reimbursement), pharmacies (to call in any new prescriptions or to approve of any prescription refills) and all other entities that you authorize Dr. Green to communicate with. If specific entities are not designated, Dr. Green will not communicate with, or provide information to, any entity concerning you or your healthcare that is not otherwise protected under HIPAA regulations.

Patient's Name _____ Social Security_____

Person(s) or entity(ies) authorized to use/disclose this information

DAVID GREEN, M.D., P.A.

Person(s) or entity(ies) authorized to receive this information

1) _____

2) _____

3) _____

4) _____

Description of the information to be used or disclosed

PERSONAL HEALTH INFORMATION

I understand that if I authorize Dr. Green to release medical information described above to a person or entity, which is not a health care provider or a health plan that is subject to federal privacy regulations (for example, an attorney, an employer, a law firm), then that information could be re-disclosed by that person or entity and would no longer be protected by these privacy regulations. _____ *Patient Initials*

I understand that I may revoke this authorization in writing at any time except to the extent that action on this authorization has not already occurred. This authorization becomes effective_____. _____ *Patient Initials*

_____ _____

Patient (or Representative) Signature Date

_____ _____

Name of Personal Representative (please print) Relationship to Patient