PREFERRED MEDICAL GROUP div MHP

HIPAA AUTHORIZATION FORM

Patient Authorization for use and Disclosure of Protected Health Information

By signing below, I authorize **PREFERRED MEDICAL GROUP, div MHP (PMG)** to use and/or disclose certain protected health information (PHI) about me to any doctor or health care facility that we refer you to **with your consent and understanding.**

This authorization permits **PMG** to use and/or disclose the following individually identifiable health information about me, including but not necessarily limited to: Your handwritten and/or dictated office notes, lab, diagnostic and/or radio logic tests, therapeutic data and referral documents from other Health Care Providers, OR.

The information will be used or disclosed for the following purpose: To assist other Health Care Providers/Entities in providing your health care OR.

(If disclosure is requested by the patient, purpose may be listed as "at the request of the individual."). Included in this section is any entity that you have authorized to receive your medical records. In such cases, ALL of your chart data will be provided unless the request explicitly requests only specific information

I HAVE ACCESS TO THE FULL NPP HIPAA RULES IN THE OFFICE LOBBY AND UNDERSTAND THAT I MAY VIEW THEM AT MY LEISURE.

The purpose(s) is/are provided to that I can make an informed decision whether to allow release of the information. This authorization will expire upon your written request to rescind this authorization.

The practice will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from PMG. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it my be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at:

I HAVE BEEN OFFERED A COPY OF THIS NOTICE AT THE TIME OF THIS SIGNING

PATIENT CONSENT FORM

Use of this form is optional and not required under the HIPAA privacy rule.

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for **PMG** to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by **PMG** describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing the consent. **PMG reserves** the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **PMG**. With this consent, **PMG** may call by home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, **PMG** may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential".

With this consent. **PMG** may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that **PMG** restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow **PMG** to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that he practices has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **PMG** may decline to provide treatment to me.

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