The Country Doctor's Authorization to use and disclose private health information

Patient Name: _____

Patient Address:_____

Patient Phone _____ Patient Date of Birth _____

Information to be disclosed: _____

_____

_____

I specifically authorize the use and/or disclosure of the type of highly confidential information indicated next to the box:

_____ Information about a Mental Illness or Developmental Disability
_____ Information about HIV/AIDS Testing or Treatment
_____ Information about other Sexually Transmitted Diseases (s)
_____ Information about Substance (i.e., alcohol or drug) Abuse
_____ Information about Abuse of an Adult with a Disability
_____ Information about Sexual Assault
_____ Information about Child Abuse and Neglect

RECIPIENT: Person(s) or persons to whom the Practice may disclose health information:

_____
Address of the recipient or where my health information should be delivered:

_____

TERM: This Authorization will remain in effect:

_____ Until I revoke it in writing.
_____ From the date of this Authorization until _____
_____ Other: _____

I hereby authorize the Practice to use or disclose to the recipient(s) my health information for the term of this Authorization. I understand that once the Practice discloses my health information to the recipient, the Practice cannot guarantee that the recipient will not re-disclose my health information to a third party. Any such third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of the Practice's treatment of me.

I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to the Practice's Privacy Office at the address listed above. The revocation will be effective immediately upon the Practice's receipt of my written notice, except that the revocation will not have any effect on any action taken by the Practice in reliance on this Authorization before it received my written notice of revocation.

I may contact the Practice's Privacy Officer at The Country Doctor, 2310 Country Road, Shiloh, IL 62221-2570 or by telephone at (618) 624-6181

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. I hereby authorize the Practice to use or disclose my health information, as described above.

_____ _____ _____
Patient or guardian's signature Date Witness