INDIVIDUAL PATIENT DISCLOSURE AUTHORIZATION FORM

Interactive Health Concepts, Inc.
Gloria K. Manley, M.D.
PO Box 27467
Scottsdale, AZ 85255

Patients Name _____Date of Birth _____

I hereby give my authorization to disclose my protected health information only in the specific manner, for the named reason, and to the specific individual(s) below.

Specific description of information to be used or disclosed:

_____

_____

_____

Reason (event) for requested disclosure:

_____

_____

Person or entity requesting information: _____

Recipient of the information: _____

I understand this authorization provides that:

- I have the right to access my protected health information to be used or disclosed unless otherwise limited by my psychiatrist.
- I may revoke this authorization at any time by contacting your Privacy Officer in writing at the address above.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by HIPAA privacy rules.
- This practice will not condition treatment on my providing authorization for the requested use or disclosure.
- I will receive a copy of this completed and signed authorization form.

Signature: _____ Date: _____

Relationship to Patient (if signed by a personal representative of patient): _____