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PATIENT AUTHORIZATION

As required by the Health Information Portability and Accountabillity Act of 1996, Albert I. Tydings, MD, APMC and Hadar H. Waldman, MD may not use or diclose your health information except as provided in our Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the disclosure and/or use described herein. You may revoke this authorization at any time.

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements.

We may use or disclose your medical information to:

- Staff members, other doctors, nurses, technicians, laboratory corporations or other health care providers via mail, telephone, and electronic systems.
- For payment purposes to collection agencies and insurance companies via mail, telephone, and electronic systems.
- Family members and/or care givers.
- Funeral directors, coroner, medical examiner and/or clergy.
- Government agencies.
- Court orders, judicial administrative proceedings.
- Public health, legal authorities, and/or abuse agencies.
- Worker Compensation.
- Law enforcement officials required by law.
- Health plan organization.
- Pharmacies and/or pharmaceutical companies.

I,_____, (print name) hereby authorize the use and/or disclosure of the health information that pertains to me. I understand that information disclosed pursuant to the authorization may be re-disclosed to additional parties. I understand that, by signing this form, I am confirming my authorization for use and/or disclosure of my health information.

Signature of patient:_____ **Date** _____

This authorization will expire when the indicidual notifies this office in writing.