AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

1. I GIVE MY AUTHORIZATION TO USE AND OR DISCLOSE MY PROTECTED HEALTH INFORMATION AS DESCRIBED IN SECTION 3 BELOW.

Name: (Print) _____Soc Sec#_____

Address: _____Apt#:_____City_____State_____Zip_____

Date of Birth: _____Primary Phone #:_____Cell#_____

Work#:_____

2. EMERGENCY CONTACT INFORMATION

Name: _____Relationship:_____Phone#:_____

3. THE USE AND /OR DISCLOSURE:

A.I understand that under HIPPA regulations, my health information will be used and disclosed to my health insurance company and any medical billing clearinghouse who is involved with processing my claims , to any health care provider who is involved with my medical treatment or services to include but not limited to psychotherapy notes, HIV related illness, AIDS, mental illness and drug or alcohol treatment.

B. I understand that I may inspect or copy the protected health information described by this authorization.

C. I understand that this authorization may be revoked in writing and delivered to Delo Medical Associates at any time, except where action has been taken in reliance on an authorization I have signed.

D. I understand that information used or disclosed pursuant to this authorization could be subject to redisclosure by the recipient and if so, may be subject to federal or state law protecting its confidentiality.

E. I understand I do not have to sign this authorization in order to receive treatment from Delo Medical Associates.

F. Under these regulations the following people are authorized to have access to my health information, IE: family members, friends, nurse, home aide or legal guardian.

Name_____Relationship_____

Name_____Relationship_____

4. Method of Contact:

I authorize Delo Medical Associates to contact me in the following manner (check only):

____ Home phone____Work Phone____Cell Phone

____Leave a detailed message, ____Leave a message with a family member, ____Leave a call back # only

I have read and understand this authorization:

_____Date:_____

Signature of Patient or Personal Representative

Delo Medical Associates