Authorization for the Use or Disclosure of Protected Health Information to Family, Friend or Attorney

Compliance/Privacy Officer
JENNIFER A. MCLAUGHLIN, M.D., PLLC
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870-793-7800

As required by the Health Insurance Portability and Accountability Act of 1996 our office may not use or disclose your health information except as provided in out Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures of protected health information described herein. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning it to this office.

AUTHORIZATION SECTION

I, _____(print patient's name) hereby authorize the use and disclosure of my health information that pertains to me to:

Spouse:_____

Child:_____

Attorney:_____

Other:_____
(Name & Relationship)

I authorize Jennifer A. McLaughlin, MD, PLLC, its physicians, medical and business staff members to make these disclosures of my health information for my personal use and at my request or for my personal use.

I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and is no longer protected.

I understand that I may revoke this authorization at any time by signing the revocation section of my copy of this form and returning it to the address above. I further understand that any such a revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this authorization.

I understand that this authorization will automatically expire on _____(date is mandatory).

I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain treatment will not depend in any way on whether I sign this authorization or not.

I understand that I have a right to inspect and to obtain a copy of any information disclosed pursuant to this authorization.

I understand that the clinic named above may/will receive compensation for the uses and disclosures that I have authorized. The compensation to be received is $15.00.

_____ _____
Signature Date

REVOCATION SECTION

I hereby revoke this authorization. _____ ____/___/_____
Signature Date

Revocation received by clinic:

_____ _____
Signature Date

Copy Given to Patient_____(signature of employee)