EXAMPLE

FRANK R. BAUM, M.D., INC.
200 Kalepa Place
Kahului, Maui, HI 96732-2471
(808) 871-7116
FAX (808) 877-4134

Authorization For The Use And/Or Disclosure Of Protected Health Information

Patient Name: _____

Birth Date: _____

I authorize the use and/or disclosure of my protected health information as described below:

1. My authorization applies to the information described below. Only this information may be used and/or disclosed pursuant to this authorization (*check all that apply*):

1. OUR OFFICE WILL NOT SEND ANY INFORMATION WITHOUT YOUR APPROVAL HOWEVER, if there is a request from you, please check-off what information you would allow us to disclose

( ) All medical records
( ) Clinical Notes
( ) HIV test results *specify* ( ) Yes ( ) No
( ) Genetic test results
( ) Lab/Imaging Reports
( ) Restrict to the following dates/conditions:_____
( ) Restrict to information necessary to complete form provided
( ) X-ray Film(s)
( ) Other (*specify*) _____

2. I authorize the following persons (or class of persons) to make the authorized use and/or disclosure of my protected health information:

2. Check-off who is allowed to disclose your child's information. Remember, this includes times when you may not be available to make the decision

( ) Frank R. Baum, MD, Inc
( ) Family member (*circle*) Spouse Partner Child/Children Parent(s) Guardian
( ) Other: _____

3. I authorize the following persons (or class of persons) to receive my protected health information:

3. This allows other people to receive your child's health information, to pick up forms for you, take messages on the phone and speak to us about your child's health condition.

( ) Family member (*circle*) Spouse Partner Child/Children Parent(s) Guardian
_____ _____
_____ _____

4. I understand that, if my protected health information is disclosed to someone who is not required to comply with the federal privacy protection regulations, then the information may be re-disclosed and would no longer be protected.

5. I understand that I have a right to revoke this authorization at any time.
My revocation must be in writing (e.g., a letter) addressed to: Frank R. Baum, M.D., Inc..
I am aware that my revocation is not effective to the extent that the persons I have authorized to and/or disclose my protected health information have acted in reliance upon this authorization.

6. This authorization expires upon _____ *(insert date or an event that triggers expiration)*

6. If you write "indefinitely" in this space you will not need to sign this form every year, unless update is needed

7. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment from Frank R. Baum, M.D., Inc., nor will it affect my eligibility for benefits.

8. My protected health information will be used or disclosed upon request for the following purposes (*check as many as apply*):

( ) Personal records
( ) Continued medical care
( ) Insurance claim
( ) Legal action
( ) Other (*specify*) _____

9. I understand that I have a right to inspect and copy my own protected health information to be used or disclosed in accordance with the requirements of the federal privacy protection regulations.

I certify that I have received a copy of the authorization.

Patient Name: _____

Birth Date: _____

_____ _____

Signature Date

_____

Name

_____ _____

Name of Personal Representative Relationship to Patient

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION FOR FRANK R. BAUM, M.D. INC.

I have read the Notice of the Uses and Disclosures of Protected Health Information (the "Notice") that is posted in the office and/or web site. I hereby acknowledge that I received a copy of the Notice from Frank R. Baum, M.D., Inc. (if requested)

_____

Print Your Name

_____

Signed

_____

Date

PLEASE SIGN AND DATE TO SAY THAT YOU HAVE REVIEWED THE HIPAA NOTICE FROM OUR OFFICE