Name of Practice: First Internal Medicine, Prof . LLC – Igor Huzicka, MD & Tamara Murphy, PA-C

Authorization to Disclose or Use My Health Information

Patient name: ____ Date of birth: ___________________________

Previous name (if applicable): _______________________________________

I. My Authorization

You may use or disclose the following health care information (check all that apply):

❒ All my health information maintained by the above-named practice

(Circle "include" or "exclude" for each of the following)

Include or Exclude My health information related to alcohol or drug abuse

Include or Exclude My health information related to HIV/AIDS

Include or Exclude My health information related to psychological or psychiatric conditions

Include or Exclude My health information related to genetic testing

❒ My health information relating to the following treatment or condition: ____

❒ Limit disclosure of my health information to the following dates: From _______________ To ___________________

❒ Other: ____

You may disclose this health information to:

Name (or title) and organization: ____

Address: _________________________________ City: _______________________ State: ______ Zip: __________

Fax Number: ______________________________

Reason(s) for this authorization (check all that apply):

❒ Transfer of care to a new physician (I will establish care with a new PCP. Please archive my records.)

❒ Other (please specify): ____

This authorization ends: ________ (if no date is given, the authorization will be valid for one year from the date signed)

II. My Rights

I understand I do not have to sign this authorization form in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- To take part in a research study **OR**
- To receive health care when the purpose is to create health information for a third party.

I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the above-named practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- Fill out a revocation form. The form is available from the office. **OR**
- Write a letter to our office.

Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

____ ______________________________

Patient or legally authorized individual signature Date

____ ____

Printed name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative, etc.)