RMC Rocha MEDICAL CLINIC

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HIPAA Authorization Form

Authorization for Use or Disclosure of Protected Health Information

I authorize my physician and/or administrative and clinical staff to (check all that apply):

____ use the following protected health information, and/or

____ disclose the following protected health information to **[Name of entity or persons to receive information]:**

_____

_____

This protected health information is being used or disclosed for the following purposes:

_____

_____

[List specific purposes here. "At the request of the individual" is acceptable if the request is made by the patient, and the patient does not want to state a specific purpose.]

This authorization shall be in force and effect until date _____ event _____ at which time this authorization to use or disclose this protected health information expires. ("End of the research study" and "none" is acceptable for authorization for research purposes). I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Contact at G. Rocha, M.D., 3408 Roosevelt Ave., San Antonio, TX 78214, or **grocha99589@hotmail.com**. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

My physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.
The use or disclosure requested under this authorization will result in direct or indirect remuneration to my physician from a third party.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Print Name of Patient or Personal Representative Description of Personal Representative's Authority