

Dr. Peter McPartland

Health Care Authorization Form

Patient's Name _____

Patients SS# ___/___/___

Date Of Birth ___/___/___

THE PATIENT IDENTIFIED ABOVE AUTHORIZES DR. PETER McPARTLAND TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

1. I give permission to Dr. Peter McPartland to use my address, phone number, and clinical records to contact me with birthday cards, holiday related cards, re-call cards, newsletters and information about treatment alternatives or other health related information. As well as phone calls for missed appointments and reactivations. My name may also be written on an in office referral board as well as thank you cards and posting of pictures in office.

(OPEN ROOM AUTHORIZATION-OPTIONAL)

2. I give permission to Dr. Peter McPartland to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor at any time in private, the doctor will provide a room for these conversations.
3. By signing this form you are giving Dr. Peter McPartland permission to use and disclose your protected health information in accordance with the directives listed above.

EXPIRATION

The Authorization shall expire on the following date _____

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this AUTHORIZATION, in writing, at any time. However your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization.

Your name, Social Security number, and date of birth, a clear statement of your intent to revoke this AUTHORIZATION: The date of your request; and your signature.

The revocation is not effective until it is received by the privacy official.

This AUTHORIZATION is requested by Dr. Peter McPartland for its own use/disclosure of PHI (Minimum necessary standards apply)

You have the right to refuse to sign this AUTHORIZATION. If you refuse to sign this AUTHORIZATION, Dr. Peter McPartland will not refuse to provide treatment.

**** You have the right to inspect or copy the PHI to be used/ disclosed. ****

****A copy of the signed authorization can be provided to you.***

Print Name of Patient

Signature of Personal Representative

Signature of Patient

Description of Representative's
authority to act for patient:

Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

Patient Signature

Date

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