



**AUTHORIZATION FOR THE USE AND/OR DISCLOSURE
OF PROTECTED HEALTH INFORMATION**

I authorize the use and/or disclosure of my protected health information for _____.

1. I authorize use and disclosure of the name of my treating physician(s), the nature of my treatment, and my projected outcome (collectively referred to as "Limited PHI" – Protected Health Information) in accordance with the terms of this Authorization. I understand that my demographic information (i.e. name, contact information, age, gender and insurance status) and dates of health care service may also be disclosed pursuant to the Notice of Privacy Practices.
2. I authorize my physician and/or health care provider (s) to make the authorized use and/or disclosure of my Limited PHI to institutionally related offices.
3. This Authorization expires twelve (12) months from the date that I sign this Authorization.
4. I understand that once my Limited PHI is used and/or disclosed pursuant to this Authorization, it may no longer be protected by the HIPPA privacy regulations and may be subject to re-disclosure by the recipients.
5. I understand that I have a right to revoke this Authorization at any time. My revocation must be in writing as described in the Notice of Privacy Practices. I am aware that my revocation is not effective to the extent that I have authorized the use/or disclosure of my PHI and such use and/or disclosure has been relied upon by authorized recipients.
6. 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 **TrueMedicine**, nor will it affect my eligibility for benefits.
7. 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 Notice of Privacy Practices.
8. I certify that I have received a copy of this authorization. _____ (Initial)

Patient
Signature _____ DOB _____

-OR-

Patient Representative _____

Representative Signature _____

Relationship to Patient _____

FOR OFFICE USE ONLY:

TO: _____ FAX: _____