PROVIDA HEALTH CENTER, SC

PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE PROTECTED HEALTH INFORMATION TO THIRD PARTIES

I authorize Provida Health Center, SC ("the practice") to use and/or disclose certain protected health information (PHI) about me to or for the party or parties listed below.

1._____ 2._____

3._____ 4._____

This authorization permits the practice to use or disclose the following individually identifiable health information:

☐ Entire Medical Chart	☐ Cardiology/EKG Reports
☐ Immunizations	☐ Lab/Path Reports
☐ Operative/Procedure Reports	☐ Radiology/Xray/MRI Reports
☐ Appointment Times and Reasons	☐ Physicians Office Note

Other: _____

This authorization will expire on: _____ ☐ No expiration date.

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to a duly authorized representative of the practice at its office in Grayslake, Illinois.

☐ I do not authorize Provida Health Center, SC ("the practice") to use and/or disclose any protected health information (PHI) about me.

Signed by: _____ _____

Signature of Patient or Legal Guardian — Relationship to Patient

_____ _____

Patient's Name — Date

_____

Print Name of Patient or Legal Guardian