DR. MARK LINDEMANN
DO PA AND ASSOCIATES
INTERNAL MEDICINE

Patient Authorization for Practice to Release Protected Health Information

Our Notice of Privacy provides information about how we may use and disclose protected health information (PHI) about you. On occasion, the patient and the Practice may want to use PHI for reasons other than treatment, payment, and health care operations, or for other purposes permitted by law. This form summarizes the anticipated use of information about you for which this authorization is required. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act (HIPAA).

- Leave a message on your answering machine regarding appointments? **YES or NO**
- Leave a message on your answering machine regarding lab and pathology results or any other health care issues? **YES or NO**
- Contact you at your place of employment regarding appointments, labs and pathology results or any other health care issues? **YES or NO**
- Discuss your medical condition with any member of your household? Please list below **YES or NO**

_____

_____

_____

_____

Expiration date of this authorization: ONE YEAR FROM DATE OF SIGNATURE

The above mentioned Protected Health Information may be subject to re-disclosure by the party receiving the information and may no longer be protected by the privacy rules.

To the extent that this form authorizes the sale of your Protected Health Information, such a disclosure will result in remuneration to the Practice.

By signing this form, you authorize the Practice to use and disclose Protected Health Information about you for the reasons mentioned above. You have the right to revoke this authorization at any time, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior authorization. Submit your revocation to the Privacy Officer of the Practice

This authorization was signed by: _____
Sign Name – Patient or Representative

Print name _____
Print Name – Patient or Representative

Relationship to Patient (if other than patient): _____

Date: _____