Authorization to Disclose Protected Health Information

Dr. Janene Martin, ND, 2345 York Rd., Suite 102, Timonium, MD 21093

Patient Name**:** _____ Address: _____

Phone: _____ Date of Birth: _____/_____/_____

In an effort to help all of your healthcare practitioners best serve you I ask your permission to update your other practitioners with our goals, plans and progress.
After our first visit I will send out a letter informing them of our contact and inviting any further dialogue about your ongoing care.

** Please **DO NOT SIGN** the permission below If you do not wish to have me contact any or all of your practitioners.**

_____ ____/____/___
Signature of Patient or Patient's Authorized Representative (relationship) Date

As required by the Privacy Regulations, Dr. Janene Martin may not use or disclose your protected health information except as provided in the Notice of Privacy Practices without your authorization.

I hereby authorize: Dr. Janene Martin, ND

Address: 2345 York Rd, Suite 102 Phone (410) 296-4005
Timonium, MD 21093 Fax (410) 296-4636

to disclose my Patient Health Information to: _____

Address: _____
Street number City State Zip

Phone: _____ Fax: _____

*By **initialing** the spaces below, I authorize the release of the following records, if such records exist:*

The following items must be initialed to be included in other documents:

___ HIV/AIDS related record ___Mental Health records
___ Drug/Alcohol diagnosis, treatment or referral information ___Genetic testing information

(Federal regulations require a description of how much information and what kind of information is to be disclosed). Describe_____

For the specific purpose of (describe in detail):

This authorization will expire 180 days from the date of signing.

I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond our control.

I understand I have the right to:

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of Patient Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.
7. I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health information.

_____ _____/_____/_____

Signature of Patient or Patient's Authorized Representative (relationship) *Date*