Wendy R. Hurst, MD, LLC
AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: ____

Address: ______________________ City __________ ST______ZIP____________

Date of Birth: __________________ Today's Date: ____________________

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

The practice will use and disclose protected health information without notice for the purpose of treatment, obtaining payment, or supporting the day-to-day operations of the practice.

I hereby authorize this office and any of its employees to use or disclose my Patient Health Information to the following person (s), or business associates of this office not related to obtaining payment (insurance or other payer) or treatment (referring physician or referred physician) as described above:

Name	Phone	Relationship
____________________	( ) -	__________
____________________	( ) -	__________
____________________	( ) -	__________
____________________	( ) -	__________

Effective Date for this authorization is the signed date and will stay in affect until office has written notice of expiration except in the case of a minor. If patient is under the age of 18 years of age at time of this authorization release the expiration is effective immediately on patient's 18th year birthday._____/______/_____

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. Inspect a copy of Patient Health Information being used or disclosed under federal law.
3. Refuse to sign this authorization.
4. Receive a copy of this authorization.
5. Restrict what is disclosed with this authorization.

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.

I have received a copy of Wendy R. Hurst, MD, LLC Notice of Privacy Practices and understand my rights.

______________________________ ______________________
Signature of Patient or Guardian Date

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Printed Name of Patient or Guardian