HARDIN PROFESSIONAL SERVICES

Facility: ___________________________________

Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I hereby authorize Hardin Professional Services to use or disclose protected health information (Labs, X-ray Reports, etc.) about me to only the following people:

Name:	**Relationship:**

The authorization will expire on: Indefinitely or _________________________________ (Date of Expiration).

- The practice will not receive payment from a third party for using or disclosing Personal Health Information (PHI).
- I may inspect or copy the PHI to be used or disclosed.
- When my information is used or disclosed pursuant to the authorization, it may be subject to re-disclosure by the recipient and no longer protected by the federal HIPPA Privacy Rule.
- I do not have to sign this authorization in order to receive treatment from Hardin Professional Services. I have the right to refuse to sign this authorization.
- I have the right to revoke this authorization by submitting a written request to this office.

I wish to be contacted in the following manner (check all that apply):

Home Telephone: ______________________________
- ☐ O.K. to leave a detailed message
- ☐ Leave just a call-back number

Written Communication:
- ☐ O.K. to mail medical information to my home address.

Cell Phone Number: ____________________________
- ☐ O.K. to leave a detailed message
- ☐ Leave just a call-back number

Work Phone Number: ____________________________
- ☐ O.K. to leave a detailed message
- ☐ Leave just a call-back number

*** If any of this information should change, it is your responsibility as our patient to notify us of the changes.**

____
Printed Name

____
Patient Signature **Date/Time**

If signed by a medical POA, legal documentation must be presented at time of service.

____ ___________________________
Authorized Signature **Date/Time** **Relationship to Patient**

A signed copy of this authorization form will be provided upon request.