

INDIVIDUAL PATIENT'S AUTHORIZATION

HUNTSVILLE INTERNAL MEDICINE ASSOCIATES, INC.
250 Chateau Drive, Suite 220
Huntsville, Alabama 35801
(256) 881-1989

Name _____ DOB _____ Social Security # _____

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination, and test results, diagnosis, treatment and any plans for future care and treatment. I understand that the Red Flag Rules are applied.

I understand that, if the persons or organizations I authorize to receive and/or use the protected health information described below are not health plans, health care providers or healthcare clearinghouses subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

I understand that this information serves as:

- A basis for planning my care and treatment.
• A means of communication among the many healthcare professionals who contribute to my care.
• A source of information for applying my diagnosis and surgical information on my bill.
• A means by which a third-party payer can verify that services billed were actually provided.
• A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have a right:

- To inspect or copy the protected health information to be used or disclosed.
• To request restrictions as to how my health information may be used to carry out treatment, payment or healthcare operations – and that the organization is not required to agree to the restrictions requested.
• To refuse to sign authorization.
• To a statement that covered entity may receive remuneration from use or disclosure of requested information.
• To copy of this form.

I understand that I may revoke this authorization at any time by giving written notice. However, I understand that I may not revoke this authorization for any actions taken before receipt of my written notice to revoke this authorization or if the covered entity had taken action in reliance thereon. In addition I understand that I am giving this authorization as a condition of obtaining insurance coverage, and I revoke this authorization, the insurance company has a right to contest my claims under the insured policy.

Specifically described the information to be used or disclosed, such as date(s) of service, level of detail to be released, origin of information, etc.

The information will be used or disclosed for the following purpose ("at the request of the individual" is sufficient description of the purpose when an individual initiates the authorization and does not, or elects not to, provide a statement of the purpose):

I request the following restrictions to the use of my health information:

Name/Identification of person(s) to whom the covered entity may make the requested use or disclosure:

Expiration date or event that relates to the individual or purpose of the use of disclosure:

Signing this authorization is not a condition of treatment. My physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party. I agree with the Red Flag Rules that state that my identity is correct.

Individual Patient's Signature

I have had the chance to read and think about the consent of this authorization form and I agree with all the statements made in this authorization. I understand that by signing this form, I am confirming my authorization for use and/or disclosure of the protected health information described in this form with the people and/or organizations named in this form. I agree with the Red Flag Rules that state that my identity is correct.

X _____ Date _____ Witness Signature _____
Signature of Patient or Legal Representative

I acknowledge receipt of the Notice of Privacy Practices form, which details how Protected Health Information may be used and disclosed, and how I may access that information.

X _____ Date _____ Witness Signature _____
Signature of Patient or Legal Representative