INDIVIDUAL PATIENT'S AUTHORIZATION

ISBELL MEDICAL GROUP, P.C.
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P.O. Box 680199
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Telephone: (256) 845-3121

❑ Check if this authorization is for psychotherapy notes.

If this authorization is for psychotherapy notes, you must *not* use it as an authorization for any other type of protected health information.

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, diagnoses, treatment and any plans for future care or treatment.

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 health care 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 to 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 the 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 or disclosed to carry out treatment, payment or healthcare operations - and that the organization is not required to agree to the restrictions requested, except for requests to restrict disclosures to a health plan if the disclosure is for payment or health care operations and pertains to a health care item or service for which you have paid your health care provider out of pocket in full prior to the service.
- To refuse to sign the authorization.
- To a statement that covered entity may receive remuneration from use or disclosure of requested information.
- To a copy of this form.
- To receive notification in the event of a breach.

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 if 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 insurance policy.

Specifically describe 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 a 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 or disclosure 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 the purpose of the use or 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.

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 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.

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

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