SUBMIT FORM

Center for Natural Medicine P.A.

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Winona, MN 55987

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Authorization to Use or Disclose Protected Health Information

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

SECTION A

Must be completed for all authorizations.

I hereby authorize the use/disclosure of my health information as described below. I understand that this authorization is voluntary. I understand that any and all records, whether written, oral, or in electronic format are confidential and cannot be disclosed without my prior written authorization except as otherwise provided by law. I understand that a photocopy or fax of this authorization is as valid as the original.

Patient Name:	Date of Birth:
Person(s)/Organizations authorized to use/disclose information (from):	Person(s)/Organizations authorized to receive information (to): Center for Natural Medicine 902 E. 2nd Street, Suite 325, Winona MN 55987 507-452-6640 phone, 507-452-6646 fax

Information that may be used/disclosed.

(Include dates where appropriate, e.g., medications dispensed in December 2002 or EKG Report performed in June 2000)

- ☐ Record of Visits (all) _____
- ☐ Record of Specific Visit(s) _____
- ☐ Discharge Summary _____
- ☐ History/Physical _____
- ☐ Consultation Report(s) _____
- ☐ Operative Report(s) _____
- ☐ Problem List _____
- ☐ Progress Notes _____
- ☐ Medication _____
- ☐ Nutritional Pharmaceutical Recommendations _____
- ☐ Other (state information & dates):

_____

_____

_____

- ☒ Laboratory Report(s) In-House _____
- ☒ Laboratory Report(s) Outside _____
- ☐ X-Ray, MRI, CT _____
- ☐ Echo, Stress Tests, Holters _____
- ☐ EKG Report _____
- ☐ Mental Health/Alcohol/Drug Abuse Treatment _____
- ☐ AIDS or HIV Information _____
- ☐ Hepatitis Information _____
- ☐ Entire Medical Record _____
- ☐ Statement of Charges/Payments _____

SECTION B

Must be completed only if a health provider or health plan has requested the authorization.

The health plan or health care provider must complete the following. The information will be used/disclosed for the following purposes:

- ☒ Continued Patient Care
- ☐ Disability Determination
- ☐ Personal Use
- ☐ Attorney/Legal
- ☐ Insurance Claim
- ☐ Other _____

SECTION C

Must be completed for all authorizations.

I understand that I have the right to:

1. Revoke this authorization at any time by notifying the Privacy Officer in writing. I understand that the revocation will not apply to information that has already been released in repose to this authorization. **This authorization expires one year from date signed.** Date or event that triggers expiration: _____

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. 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 Representative | Date

_____ _____

Printed Name of Patient's Representative (if applicable) | Relationship to Patient