



# REGENCY HEALING MEDICAL CLINIC

*Healing And Preserving Our Community*

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## PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize \_\_\_\_\_ to use and/or disclose certain protected health information (PHI) about me to: **Regency Healing Medical Clinic.**

**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

This authorization permits **Regency Healing Medical Clinic** to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as dates(s) of services, type of services, level of detail to be released, origin of information, etc.):

\_\_\_\_\_  
\_\_\_\_\_

The information will be used or disclosed for the following purpose:

\_\_\_\_\_

If requested by the patient, purpose may be listed as “at the request of the individual.” The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on [date]: \_\_\_\_\_, or defined event.

The Practice will \_\_\_ will not\_\_\_ receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from the Practice. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy and Security Officer at: **817 – 453 – 2323**

Patient’s Name: \_\_\_\_\_

Patient’s DOB: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_