INTERNAL MEDICINE DIAGNOSTICS

197 HOSPITAL DR., SUITE # B
CHEROKEE VLG, AR 72529
PHONE: 870-257-5118 FAX: 870-257-5126

Authorization for Use or Disclosure of Health Information

Patient Name: _____ Date of Birth_____

I hereby authorize the use and disclosure of my protected health information by Internal Medicine Diagnostics for the purpose of diagnosing or providing treatment to me obtaining payment for my health care bills or to conduct health care operations of Internal Medicine Diagnostics. I understand that diagnosis or treatment of me by Internal Medicine Diagnostics may be conditioned upon my consent as evidence by my signature on this document.

I understand I have the right to request a restriction as to how my protected information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Internal Medicine Diagnostics is not required to agree to the restrictions that I may request. However, if Internal Medicine Diagnostics agrees to a restriction that I request, the restriction is binding on Internal Medicine Diagnostics.

Authorized Information will be used and/or disclosed for the following purposes:

I have the right to revoke this consent, in writing, at any time, except to the extent that Internal Medicine Diagnostics has taken action in reliance on this authorization.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another healthcare provider, a health plan, my employer or a healthcare clearing house. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is reasonable basis to believe the information may identify me.

I understand I have the right to review Internal Medicine Diagnostics **Notice of Privacy Practices** prior to signing this document. The Internal Medicine Diagnostics' **Notice of Privacy Practices** has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of healthcare operations of the Internal Medicine Diagnostics.

The Notice of Privacy Practices for Internal Medicine Diagnostics is also provided in HIPAA Compliance Department by the Privacy Official. This Notice of Privacy Practices also describes my rights and Internal Medicine Diagnostics duties with respect to my protected health information. Internal Medicine Diagnostics reserves the right to change the privacy practices that are described on the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling Internal Medicine Diagnostics office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative

Name of patient or Personal Representative

Description of Personal Representative's Authority Date