

CLASSICAL MEDICINE OF ST. PETERSBURG, INC.

Patient Authorization for Use & Disclosure of Protected Health Information

I understand that as a part of my health care, the practice originates and maintains paper &/or electronic records describing my health history, symptoms, examination & test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

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

I have been provided with a “Notice of Patient Privacy Practices” that offers a more complete description of information uses and disclosures. I understand I have the following rights and privileges:

- The right to restrict or revoke the use or disclosure of my health information for other uses or purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

Restrictions

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

Please provide the name/s of individuals with whom we may discuss your protected health information:

[ex: spouse (name); children (name/s); relatives/care-givers/friends (names)]

Messages & Appointment Reminders

May we leave a message at your **home** or on your **cell** using practitioner’s name? Yes () No ()
 May we leave a message at your **work** using practitioner’s name? Yes () No ()

I understand that as part of treatment, payment, or healthcare operations, it may become necessary to disclose health information to another entity, i.e., referrals to other health care providers. I consent to such disclosure for these uses as permitted by law.

I fully understand and **accept / decline (please circle one)** the information of this consent.

Patient or Representative or Guardian Signature

Printed Name

Relationship to Patient (if other than patient)

Date: _____