Patient Authorization Form

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McMurray, PA 15317
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I hereby authorize you to use or disclose the specific information described below, only for the purposes and parties also described below.

Description of specific information to be used or disclosed:
Name, address, date and time of appointment.

Recipient of the information:
Anyone living in the same household.

This information is being requested for the following purposes(s):
Postcard and telephone reminder of an appointment.

This authorization shall remain in effect from the date signed below as long as I am a patient in this office.

I understand that:

- I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this authorization in writing by contacting your office at the address above, attention Privacy Officer.
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected by HIPAA.
- I may refuse to sign this authorization and that you will not condition treatment or payment on my providing this authorization, (except to the extent that the authorization is for research-related treatment, in which case you may refuse to provide that research-related treatment).

Patient Name: _____

Relationship to Patient (if signed by personal representative of Patient): _____

Signature: _____

Date: _____