Patient Authorization for Use/Disclosure of Specific Protected Health Information

Patient's name: ______________________ Date of birth: ____________
SSN: ______________________ Previous name: ______________________

I request and authorize ______________________. to release healthcare information of the patient named above to:

Dena Petersen, M.D., P.C.
4574 N. First Avenue, Suite 180
Tucson, Az 85718

This request and authorization applies to:

_____ Healthcare information relating to the following treatment, condition, or dates of treatment:
____
____

_____ All healthcare information
_____ Other: ________ for continuing care

The protected health information will be used and/or disclosed for the following purposes:

_____ At the request of the individual.
_____ Other: ____________for continuing care

I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.

In addition to the general authorization to release records to the persons or entities listed above, I authorize the release of the records described as the following:

Communicable disease-related information, including records of testing, diagnosis, or treatment for HIV, HIV-related illness, AIDS, AIDS-related diseases.	☐Yes	☐No
Drug and alcohol treatment.	☐Yes	No☐
Psychological/psychiatric information, including diagnosis and treatment.	Yes☐	No☐

I may revoke this authorization to the extent allowed by law. If I do, I understand that Dena Petersen, M.D., P.C. may have already released information about me after I gave permission. **I understand that I cannot revoke this authorization retroactively for information already released.**

There are two ways to revoke this authorization. I can:

1) sign and date a form available from Dena Petersen, M.D., P.C. called "Revocation of Authorization for Use and Disclosure of Healthcare Information"; or,
2) write a letter to Dena Petersen, M.D., P.C. If I write a letter to Dena Petersen, M.D., P.C., it must say that I want to revoke my authorization to disclose the patient's healthcare information. My letter must include the name or other specific identification of the person(s) that I no longer want to receive information. I (or my authorized representative for healthcare) must sign and date the letter.

Once ______________________ gives out the information that I want released, I know that ____________ has no control over the information. The individual or organization that I authorized to receive the information might redisclose it. Federal or state privacy laws may no longer protect the information.

____
Signature of patient or patient's authorized representative Date signed

____
Relationship or status if signed by anyone other than patient (parent, legal guardian, personal representative, etc.)

This authorization expires on ______________________ or when the following event occurs

____

Dena Petersen, MD, PC

Patient Consent for Use and Disclosure of Protect Health Information

I hereby give my consent for **Dena Petersen, M.D., P.C**. to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). In general, there will be no other uses and disclosures of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual. One example would be if a patient threatened to hurt someone. The Notice of Privacy Practices provided by **Dena Petersen, M.D., P.C.** describes such uses and disclosures more completely.

I have the right to review the Notice of Privacy of Procedures prior to signing this consent. **Dena Petersen, M.D., P.C**. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Dena Petersen, M.D., P.C., 4574 N First Avenue, Suite 180, Tucson, AZ 85718** or requesting one in person.

With this consent, **Dena Petersen, M.D., P.C**. may call my home or an alternative location of my choosing and leave a message on voicemail or in person in reference to any items that may assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, **Dena Petersen, M.D., P.C**. may mail to my home or an alternative location of my choosing any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

I have the right to request that **Dena Petersen, M.D., P.C**. restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

My signature below indicates that I have been given the chance to review a current copy of Dena Petersen M.D., P.C.'s "Notice of Privacy Policies." By signing this form, I am consenting to allow **Dena Petersen, M.D., P.C**. to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **Dena Petersen, M.D., P.C**. does not have to provide treatment to me.

Designated Contact Information

In order that we may respect your privacy, please tell us which of the following numbers we should call to communicate with you regarding Appointment Reminders, Lab Results, etc. Only list the phone number(s) that you would like us to call.

Home ______________________ Work______________________ Cell______________________

If you wish to receive mailings regarding Lab Results, etc. at an address *other than* your home address, please list it below.

May we leave test results with your significant other? ________ yes __________ no

Is there anyone else at the above numbers we may leave test results with (ex/ parents)? If so, please list name(s) and relationship(s) below.

______________________________________ ____________________________ ____________

Signature of Patient or Legal Guardian | Print Patient's Name | Date