Kurtis A. Waters MD PA

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Patient's Authorization for Use or Disclosure of Protected Health Information

Name: _____Date:_____

By signing this authorization, I hereby authorize Kurtis A. Waters MD PA to use and/or disclose my protected health information ("PHI") as indicated below.

I understand that this authorization is voluntary and that I may revoke this authorization at any time, except to the extent that action has been taken in reliance on this authorization. I also understand that if the individual or organization authorized to receive this information is not required to comply with the current Privacy Rule, my PHI may be disclosed to others and no longer protected by the current federal Privacy Rule.

____ Complete health care record(s)

____ Progress Notes /Office Visit Notes

____ Laboratory Reports

_____ Photographs, Other Digital Images

____ Medical/Treatment Records

____ Radiology Reports

____ Pathology Reports

____ Billing Statements

___ Other:_____

The information checked and/or listed above is to be released to: _____(Name/Address of the entity to receive this information) for the purposes of:

____ Assisting with claims resolution

____ Insurance or other benefit eligibility or coverage

____ Litigation, potential litigation, or other adversarial proceedings

____ Other:_____

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_____(Expiration Date). .

I understand that the individual, organization, or entity receiving my PHI may receive financial or in-kind compensation in exchange for using or disclosing the PHI described above.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.

I understand that I may access and copy any PHI used or disclosed under this authorization. I understand that a fee may be charged for such copying services.

I hereby release Kurtis A. Waters MD PA, its employees, officers and health care professionals from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

I understand that I may revoke this request at anytime by providing Kurtis A. Waters MD PA with my written notice of such revocation.

Signature:_____Date:_____

Printed Name:_____

OR

Signature of personal representative:_____ Date: _____

Printed Name of personal representative:_____

Relationship to patient:_____

Signature of witness or legal counsel:_____ _Date:_____

Printed Name of witness or legal counsel:_____