CULLMAN INTERNAL MEDICINE, P.C.

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Patient Address: _____ SSN: _____

_____

By signing below, you hereby authorize us to use or disclose information about yourself (or another person for whom you have the authority to sign) that is protected under federal law, for the sole purpose and time period described below. You may refuse to sign this authorization. Subject to certain exceptions, you have the right to inspect and copy the protected health information. Information to be used or disclosed (must be identified in a specific and meaningful fashion); and purpose to the use and disclosure:

Please list the family members or others persons, if any, we may inform about your general medical condition and your diagnosis, which might include medical history, treatment, laboratory reports, x-rays, and treatment and /or reference to any mental or nervous disorders, drug, an/or alcohol abuse, or sexually transmitted disease.

_____ *Relationship:* _____

_____ *Relationship:* _____

_____ *Relationship:* _____

Please list the family members or other persons, if any, we may inform about your general medical condition and your diagnosis ONLY in an emergency situation:

_____ *Relationship:* _____

_____*Relationship:* _____

This information about you is protected under federal law, and you have the right to revoke this authorization in writing. Please be advised, however that any revocation will be effective only to the extent we have not already taken action in reliance on your authorization. By signing below, you recognize that the protected health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of this disclosure and may no longer be protected under federal law. We will not condition treatment based on your authorization. You may refuel to sign the authorization.

_____ _____

Patient Signature or Personal Representative Date

As a personal representative, I have authority to act for the individual because I am:_____