Authorization for Kathleen Rein, M.D., PLLC to Use or Disclose My Health Information

Patient Name: _____ Date of Birth: _____

Previous Name: _____

I. My Authorization

You may use or disclose the following health care information (check all that apply):

□ All my health information maintained by Kathleen Rein, M.D., PLLC (except psychotherapy notes)

□ My health information relating to the following treatment or condition: _____

□ My health information for the date(s): _____

□ Psychosocial Information □ Alcohol and Drug Abuse Treatment Information □ Psychotherapy Notes

You may disclose this health information to:

1. Name and organization _____ Phone/Fax: _____

Address: _____ City _____State___ Zip ____

2. Name and organization _____ Phone/Fax: _____

Address: _____ City _____State___ Zip ____

3. Name and organization _____ Phone/Fax: _____

Address: _____ City _____State___ Zip ____

Reason for this authorization (check all that apply):

□ At my request □ Other (specify): _____

This authorization ends: □ On (date) _____ □ When the following event occurs: _____

II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment, or enrollment). However, I do have to sign an authorization form to take part in a research study or to receive health care when the purpose is to create health information for a third party.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Kathleen Rein, M.D., PLLC based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. To revoke this authorization, I need to write a letter to the office. Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_____ Date _____ Time _____

Patient signature

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