Stephen R. Marks, M.D., P.A.

AUTHORIZATION TO DISCLOSE HEALTHCARE INFORMATION

Patient Name:____ Health Record No.:________________________________

I voluntarily authorize this clinic to release the protected healthcare information ("PHI") of the person above to:

Person/Company providing the information:	Persons/Companies receiving the information:
_______________________________________	_______________________________________
_______________________________________	_______________________________________
_______________________________________	_______________________________________

Specific information to be released with dates: ____

____

Purpose: a. If requested by the Patient/Patient's Personal Representative: (1) At the request of the individual.

b. Other: (Must complete)____

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Section A. Must be completed if health plan insurer or health care provider has requested the information.

1. a. The purpose of this disclosure is____
   b. This disclosure will result in direct or indirect payment to the physician: Yes____No____

2. The patient or personal representative must read and initial:
   a. I understand that my health care/treatment and the payment for my healthcare will not be affected if I do not sign this form. Initials:______________________
   b. I understand that I may see and copy the information described on this form, if I ask for it, and that I get a copy of this signed form. Initials:______________________

Section B. Must be completed for all authorizations.

The patient or the patient's personal representative must read and initial the following:

1. I understand that this authorization will expire on______/______/______or when the following event occurs: ____. Initials:______________________
2. I understand that I have the right to revoke this Authorization at any time by notifying the clinic in writing, but it won't Affect the actions taken before the clinic received the revocation. I understand that my personal representative or I must sign and date the letter of revocation. Initials:______________________
3. Once this clinic gives out this information I want released, I know that the clinic has no control over the information.
   The person or company authorized to receive the information might re-disclose it without my knowledge or approval. Federal and state laws would no longer protect the information. Initials:______________________
4. I understand that treatment, payment, enrollment and benefits may not be conditioned upon my signing this Authorization. Initials:______________________

____ ______________________________

Patient Signature/Patient's Personal Representative Date

If Personal Representative, explain the relationship or authority to act for the patient:_____________________________

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