Patient Authorization Form

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To: _____

_____

_____

I hereby authorize you to disclose the specific information described below, only for the purposes and parties below also described.

Description of the specific information to be disclosed:

[ ] Office Notes: _____

[ ] Pathology Reports: _____

[ ] Lab Results: _____

Recipient of the information: Jacquelyn B. Garrett, M.D.

This information is being requested for continuity of care.

This authorization shall remain in effect from the date signed below until _____ (expiration date or event)

I understand that:

- I may inspect or copy the protected health information to be used or disclosed
- I may revoke this authorization in writing by contacting your office at the address above, attention Privacy Officer.
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by HIPAA.
- I may refuse to sign this authorization (except to the extent that the authorization is for research-related treatment, in which case you may refuse to provide that research-related treatment).

Patient Name:_____ Date of Birth: _____

Signature: _____ Date: _____

Relationship to Patient (if signed by personal representative of Patient): _____