Authorization for the Use or Disclosure of Protected Health Information & Transfer of Medical Records Request

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As required by the Health Insurance Portability and Accountability Act of 1996, our office may not use or disclose your health information except as provided in our Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures of protected health information described herein. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning it to this office.

AUTHORIZATION SECTION

I, _____(Print Name) _____(Date of Birth) hereby authorize the use and disclosure of the following health information that pertains to me:

_____All my medical records _____Imaging & Reports _____Other:_____

For the purpose(s) of: _____Personal use _____Transfer to another Physician

I authorize the following persons to make these disclosures of my health information:

1) Dr. Randy D. Walker,
2) Angie Walker,
3) Sam Cobb,
4) Heather Morris,
5) Amy Mills,
6) Shawna Talkington,
7) Stacy Barnes,
8) Phyllis K. Keeney,
9) Rachel Lovell.

I authorize the following persons to receive these disclosures of my health information:

Family Member _____Physician _____

I understand the information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer protected. I understand that I may revoke this authorization at any time by signing the revocation section of my copy of this form and returning it to the address listed above. I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this authorization.

I understand that this authorization will automatically expire on _____.

I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain treatment will not depend in any way on whether I sign this authorization or not. I understand that I have a right to inspect and to obtain a copy of any information disclosed pursuant to this authorization. I understand that the clinic named above may/will receive compensation for the uses and disclosures that I have authorized.

_____ _____
SIGNATURE DATE

REVOCATION SECTION

I, _____ hereby revoke this authorization. Date:_____

Revocation received by:_____. Date:_____