HIPPA AUTHORIZATION

Authorization for Use/Disclosure of Protected Health Information

I,_____, hereby authorize **Mound Family Practice Associates**, **Inc**. to (check those that apply):

_____use the following protected health information, and/or

_____disclose the following protected health information to

_____

_____

_____

(Specifically describe the information to be used or disclosed.)

This protected health information is being used or disclosed for the following purposes:_____

_____

_____

This authorization shall be in force and effect until_____ (specify 1) date or (2) event that related to the patient or the purpose of the use or disclosure) at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Christian Taylor, Privacy Officer, 2115 Leiter Rd., Miamisburg, Ohio 45342. I understand that a revocation is not effective to the extent that Mound Family Practice Associates, Inc. has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

Mound Family Practice Associates, Inc. will not condition my treatment or payment on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to:

Inspect or copy the protected health information to be used or disclosed a permitted under federal law (or state law to the extent the sate law provides a greater access rights). Refuse to sign this authorization.

_____ _____

Signature of Patient or Personal Representative Date

_____

Representative Relationship