Authorization for Use/Disclosure of Patient's Individually Identifiable Health Information

This authorization grants permission to A New Image to use and disclose your protected health care information for the purposes of treatment and various activities associated with payment of services rendered by this office. Our Notice of Privacy Practices provides more details on how information about you may be used and/or disclosed and describes certain rights you have regarding your healthcare information. We reserve the right to change our privacy practices and will issue a revised notice should this occur.

This authorization grants permission to the Designated Party(ies) named below to: make or confirm appointments; have access to x-rays, laboratory, or test findings; have access to telephone communications and answering machine messages, as well as other common means of communication; **pick up medications and/or supplements**; be made aware of my diagnosis, prognosis, treatment plans; and have access to my financial health information. **Unless otherwise noted below, this Authorization grants A New Image permission to leave messages on my answering machine/voicemail using my protected health information** pertaining to: scheduling or confirming appointments; information related to x-ray, laboratory, or test/procedure findings; information regarding my diagnosis, prognosis, and treatment; and my financial health information as well as any other information deemed appropriate/necessary by my health care provider(s).

I hereby authorize A New Image to use/disclose my individually identifiable health information as described above. I understand that this authorization is voluntary. I understand that once this information is released, it may no longer be protected by federal privacy regulations.

Patient name: _____ SSN: _____
Date of Birth: _____
Phone Number: (____)_____ Cell Number: (____)_____

☐ **PLEASE DO NOT LEAVE MESSAGES ON ANSWERING MACHINE**

By assigning a designated party, A New Image will be allowed to give information to the following individuals:

Designated Party: _____ Relationship to patient: _____

Phone Number: (____)_____ Cell Number: (____)_____

Designated Party: _____ Relationship to patient: _____

Phone Number: (____)_____ Cell Number: (____)_____

Designated Party: _____ Relationship to patient: _____

Phone Number: (____)_____ Cell Number: (____)_____

PLEASE READ THE STATEMENTS BELOW BEFORE SIGNING THIS DOCUMENT

1. I acknowledge that I have received a copy of our Notice of Privacy Practices, have read its contents, and have had any questions answered to my satisfaction.
2. I understand that I am giving A New Image my consent to use and disclose my healthcare information to carry out treatment and payment activities.
3. I understand that I may revoke this Authorization at any time by notifying A New Image in writing; however, if I do revoke the Authorization, it will not have any affect on any actions taken by A New Image prior to their receipt of the revocation.
4. I understand that my treatment cannot be conditioned on whether or not I sign this Authorization.
5. I understand that this Authorization will be in effect for lifetime of the patient unless revoked by the patient.

_____ _____
Signature of Patient or Patient's Representative Date

_____
Printed Name of Patient's Representative

Authority: ☐ Power of Attorney ☐ Other: _____