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STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Information to be used or disclosed

The information covered by this authorization includes: _____

_____

_____

PLEASE MAIL RECORDS UNLESS OTHERWISE INDICATED

Persons authorized to use or disclose information
Information listed above will be used or disclosed by:

PROVIDERS AND STAFF OF ROBERT B. NOLAN, JR., M. D., PLLC

Persons to whom information may be disclosed **we are sending records to: / we are getting records from**:
Information described above may be disclosed:

Name of person or organization: _____

Address : _____

City, State, Zip: _____

I understand this will be my free copy and I am requesting that copy to be sent to the Physician above. A charge of $1.00 per page will be charged if I request these records again. _____initial
I understand that if I request my records to transfer and I have a Medicare or Medicare replacement policy that I will not be able to return to this office at a later date. _____initial

*****First free copy _____yes _____no (charge $1.00 per page) _____total pages**

Expiration date of authorization
This authorization is effective through _____/_____/_____ unless revoked or terminated by the patient or the patient's personal representative.

Right to terminate or revoke authorization
You may revoke or terminate this authorization by submitting a written revocation to Privacy Officer. You should contact the Privacy Officer to terminate this authorization.

Potential for Re-disclosure
Information that is described under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

Name of patient (print or type) _____Date_____

Birthdate_____ Social Security Number _____

Signature of patient or patient representative_____

Relationship to patient _____

Witness Signature_____Date_____