PERMISSION TO SHARE INFORMATION

AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize Verity Primary Medicine & Lifestyle to use or disclose my Protected Health Information as described below. I understand that the information I authorize a person/facility to receive may be re-disclosed and no longer protected by state and federal regulations.

Patient Name: _____ Date of Birth: _____

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL THAT THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHO?

Name _____ Relationship_____ Phone #_____

Name_____ Relationship_____ Phone #_____

Name_____ Relationship_____ Phone #_____

May we leave a detailed message on your answering machine/voice mail? Yes _____ No _____ **A detailed message would be lab or x-ray results, or a message about your medical condition.**

I understand that in the event I was treated for drug or alcohol abuse, psychiatric condition, communicable diseases including HIV/AIDS this information will be included as part of my medical record to the above-named person/facility. I understand that I have the right to refuse to sign this authorization and that my treatment, payment, enrollment or eligibility for benefits will not be conditional on signing. **This authorization is subject to cancellation/revocation at any time, by the patient or legally qualified representative, provided that the cancellation is made in writing except to the extent that:**

1. The facility has already acted on your request prior to receiving the request to cancel the authorization.

_____ _____

Signature of Patient or Legally Qualified Representative Date

_____ Relationship of Legally Qualified Representative