**TWIN FORKS FAMILY PRACTICE, LLC**

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# Patient Authorization for Use and Disclosure of Protected Health Information

The Department of Health and Human Services has established a HIPAA "Privacy Rule" in an attempt to insure that the Personal Health Information (PHI) of patients is protected for privacy. The "Privacy Rule" was also created to provide a standard for certain health care providers to obtain their patient's consent for use and disclosure of health information about the patient for the function of their health care facility, to carry out treatment, submit insurance claims and collect payment for their services.

As a patient of this practice we want you to know that we respect the privacy of your personal medical records and will take reasonable precautions to secure and protect that privacy. When it is appropriate, we provide the minimum information necessary to only those we feel are legitimately in need of your PHI.

You may refuse to consent to the use or disclosure of your PHI by submitting a statement in writing. However under this law, we have the right to refuse to treat you should you choose to refuse to disclose your PHI.

You have the right to review our privacy practices at any time, to request restrictions and revoke consent in writing. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

I hereby authorize Twin Forks Family Practice, LLC to use and or disclose Protected Health Information about me to the extent needed for the function of their health care facility, to carry out treatment, submit insurance claims and collect payment for their services.

| ______________________________ | ______________________________ |
|---|---|
| PATIENT/LEGAL GUARDIAN SIGNATURE | DATE |

I hereby give permission to Twin Forks Family Practice, LLC to speak to the following family members, home health care providers or friends regarding appointments, financial and insurance issues or specific health care information.

| NAME: | RELATIONSHIP: |
|---|---|
| ______________________________ | ______________________________ |
| ______________________________ | ______________________________ |
| ______________________________ | ______________________________ |

| ______________________________ | ______________________________ |
|---|---|
| PATIENT/LEGAL GUARDIAN SIGNATURE | DATE |

I hereby give permission to Twin Forks Family Practice, LLC to leave a detailed message with a family member, on my answering machine, voice mail or email which may include information regarding appointments, financial and insurance issues or specific health care information.

| ______________________________ | ______________________________ |
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| PATIENT/LEGAL GUARDIAN SIGNATURE | DATE |