ROCHESTER INTERNISTS, PLLC

Authorization of Use and Disclosure of Protected Health Information

1. **Appointment Reminders:** Our office may remind you of upcoming appointments by giving you an appointment card at the end of your visit, send you a reminder through the mail, call your home, cell,and/or work. If you have an answering machine, we may also leave a message regarding treatment, appointments and/or other information pertinent to your healthcare provided in our office. If you **DO NOT** wish to use any of these methods, please indicate which one you do not wish us to use on the following line:

_____

2. **Persons authorized to receive information:** Health information(Rochester Internists) collects or receives information about you may be disclosed to the following persons: (example: spouse, children, friends, relatives). **Please check one authorization below.**

_____	_____
Print Name of Person	Relationship
_____	_____
Print Name of Person	Relationship
_____	_____
Print Name of Person	Relationship

PLEASE CHECK ONE:

_____I authorized the person(s) listed above to receive all health information about appointments, treatments, and/or other information pertinent to my healthcare and/or payment for my healthcare provided at Rochester Internists, PLLC.

_____I **DO NOT** authorize the following information to be disclosed to any other parties except to me as the patient.

3. **Other uses and Disclosures:** Disclosing your health information or its use for and purpose other than those listed in the "Notice of Privacy Policies and Practices" and/or consent requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you noticed us of your decision . You have the right to request restrictions on use and disclosure of your health information.

I would like the **following restrictions** regarding the use and disclosure of my health information:

_____

Expiration Date of Authorization

This authorization is effective immediately unless revoked or terminated by the patient or patient's personal representative.

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation t oRochester Internists, PLLC.

Potential for Re-disclosure

The person or organization to which health information is sent may repeatedly disclose health information that is identified by this authorization. The privacy of this information may not be protected under the federal privacy regulations.

I hereby acknowledge that I authorize the above and have received a copy of the HIPAA law policy per my signature.

Patient name:_____ Date of Birth:_____

(Please Print)

Signature:_____ Date____/____/_____