

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION.

I AUTHORIZE THE USE / DISCLOSURE OF HEALTH INFORMATION ABOUT ME AS DESCRIBED BELOW.
(YO AUTORIZO EL USO O DIVULGACIÓN DE INFORMACIÓN DE SALUD ACERCA DE MÍ COMO SE DESCRIBE A CONTINUACIÓN)

Patient Name (Nombre del Paciente): _____

Date of Birth (Fecha de Nacimiento): _____ Patient's SSN (# Seguro Social): _____

A. Person(s) or Organization(s) authorized to provide the information (Las personas o las organizaciones autorizadas a suministrar la información):
PRIMARY HEALTHCARE ASSOCIATES, INC.

B. Person(s) or Organization(s) authorized to receive the information (Personas o organizaciones autorizada a recibir la información):

C. Specific description of the information that may be used or disclosed (including date(s)) (Descripción específica de la información que puede ser usada o revelada):

D. Specific description of how the information will be used (Descripción específica de la forma en que la información se utilizará):

- 1) I understand that this authorization will **expire** on (*Entiendo que esta autorización caducará en*) _____.
- 2) I understand that I may **revoke** this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying **PRIMARY HEALTHCARE ASSOCIATES, INC.** in writing. (*Entiendo que puedo revocar esta autorización en cualquier momento mediante notificación a PRIMARY HEALTHCARE ASSOCIATES, INC. por escrito.*)
- 3) I understand that I can **refuse to sign** this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits (if applicable). (*Entiendo que se me puede negarse a firmar esta autorización y que mi negativa no afectará mi capacidad de obtener tratamiento, pago o mi elegibilidad para beneficios (si procede).*)
- 4) I may **inspect or copy** any information used or disclosed under this agreement. (*Puedo verificar o copiar cualquier información utilizada o divulgada bajo este contrato.*)
- 5) I understand that if the person or organization that receives the information is not a health care provider or plan covered by federal privacy regulations, the information described above may be redisclosed and would no longer be protected by these regulations. (*Entiendo que si la persona o la organización que recibe la información no es un proveedor de servicios de salud o plan de normas federales de privacidad, la información descrita anteriormente puede ser redisclosed por lo que ya no estaría protegido por este reglamento.*)

Patient's Signature or Patient's Representative
(Firma del paciente o representante del paciente)

Date
(Fecha)

Printed Name of Patient's Representative
(Escribir nombre del representante del paciente)

Relationship to Patient
(Relación con paciente)

NOTE:

You have the right to know specifically what information you are authorizing for release (e.g., "results of a lab test performed on 1/4/03" or, if your entire medical record is included, "all health information.").

You have the right to know the name(s) or other identification of the person(s) or organization(s) authorized to release the information (e.g., the names of your health care provider(s)).

You have the right to know who is going to use it and what it is going to be used for. (e.g., John Smith, PhD / Research).

YOU HAVE THE RIGHT TO RECEIVE A COPY OF THIS FORM
USTED TIENE EL DERECHO DE RECIBIR UNA COPIA DE ESTE FORMULARIO

HIPAA Authorization for Release of Information

This form does not constitute legal advice and covers only federal, not state, laws.