

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Raynon A. Andrews, M.D., P.C.

I, _____, hereby authorize **Raynon A. Andrews, M.D., PC** to use and/or disclose the following protected health information to (Name of Entity to receive information):
Specifically describe the information to be used or disclosed.

This protected health information is being used and/or disclosed for the following purpose(s):
Provide a description of the purpose of each use and disclosure.

1. Complete if the authorization is for marketing purposes:

The use or disclosure requested under this authorization ___ will ___ will not result in direct or indirect remuneration to **Raynon A. Andrews, M.D., P.C.** from a third party.

2. Check one of the following statements below:

___ I understand that **Raynon A. Andrews, M.D., P.C.,** may not condition my treatment, payment, enrollment (if applicable) in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

___ I understand that if I do not sign this form, **Raynon A. Andrews, M.D., P.C.,** may not provide services to me because protected health information is solely being created for use and/or disclosure to: *(Name of Entity to receive information).*

This authorization shall be in force and effect until Date: _____ or
Event: _____ at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to **Raynon A. Andrews, M.D., P.C.,** at **1878 Jeff Rd, Suite A Huntsville, AL 35806.** I understand that a revocation is not effective to the extent that **Raynon A. Andrews, M.D., P.C.,** has relied on the use or disclosure of the protected health information. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization.

Signature of Patient or Personal Representative

Print Name of Patient or Personal Representative

Date

Relationship to Patient (or other authority to serve)

