Authorization for the Use or Disclosure of Protected Health Information

Preferred Health and Wellness
1011 Verret Street
Houma, Louisiana 70360

As required by the Health Insurance Portability and Accountability Act of 1966, Preferred Health and Wellness may not use or disclose your health information except as provided in our Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures of protected health information described herein. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning to this office.

AUTHORIZATION SECTION

I, _____ hereby authorize Preferred Health and Wellness to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and health care operations.

I have been informed that Preferred Health and Wellness has prepared a notice which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment and health care operations. I understand that I have the right to review such Notice prior to signing this authorization.

I understand that I may revoke this authorization at any time notifying Preferred Health and Wellness, in writing, but if I revoke my authorization, such revocation will not affect any actions that Preferred Health and Wellness took before receiving my revocation.

I understand that Preferred Health and Wellness has reserved the right to change the privacy practices and that I can obtain such changed notice upon request.

I understand that I have the right to request that Preferred Health and Wellness restricts how my individually identifiable health information is used and/or disclosed to carry out treatment, payment or health operations. I understand that Preferred Health and Wellness does not have to agree to such restrictions, but that once such restrictions are agreed to, Preferred Health and Wellness must adhere to such restrictions.

I understand that I am under no obligation to sign this authorization. I also understand that by refusing to sign this authorization or revoking this authorization, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____ _____ _____
Signature of Patient Print Name of Patient Date

REVOCATION SECTION

I hereby revoke this authorization.

_____ _____
Date Signature