DAVID WALBURN M.D.

PATIENT AURHORIZATION FOR USE AND DISCLOURE OF PROTECTED HEALTH INFORMATION

Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 & 164

1. Use and Disclosure of PHI

My Protected Health Information (PHI) will be used by Dr. David Walburn (from here on out will be labeled as 'The Practice') or disclosed to others for the purpose of treatment, payment, and health care operations, law enforcement or for the public health safety. The Practice will require my consent or authorization to disclose PHI for other purposes.

2. Notice of Privacy

The Practice will give me clarification of Notice of Privacy about its policies for disclosure of PHI when requested upon. This document recognizes my rights as a patient and details how my PHI will be disclosed. I shall acknowledge receipt of this notice and receive a signed copy of the notice, afterwards. If I decline not to acknowledge this notice, the Practice will not treat me.

3. Request for Restriction to Use or Disclose PHI

I may request a written restriction on the use and disclosure of my PHI. The Practice will agree to my request. It will not use or disclose my restricted PHI. Violation of this agreement will be a violation of the federal privacy standard.

4. Revocation of Authorization or Consent

I may revoke this authorization by written statement at any time. The Practice will honor my request of revocation. Any use or disclosure of my PHI prior to this date will not be affected by this revocation.

5. Reservation of Right to Change Privacy Practice

The Practice reserves the right to modify the privacy practices as outlined in the Privacy Notice.

6. Payment Authorization

I authorize payment of my medical benefits to the Practice for the services rendered to me.

7. Signature of Patient or Patient Representative

I have reviewed this authorization for and give my permission to the Practice to receive payment for my medical benefits, and to use or disclose my health information in accordance with the guidelines of HIPAA regulation.

_____ _____

Name of Patient/Guardian Date

_____ _____

Signature of Patient/Guardian Date