PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE PROTECTED HEALTH INFORMATION BY FACSIMILE

By signing this authorization, I authorize Roy B. Blumenstrauch, M.D. and staff to use and/or disclose certain protected health information (PHI) about me to or for the party or parties listed below by Facsimile.

This authorization permits Roy B. Blumenstrauch, M.D. and staff to use or disclose to _____ and to the facsimile number provided_____ the following individually identifiable health information to be released, such as date(s) of service, billing account information, insurance information, medical records and test results.

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by any disclaimer attached to the facsimile or the federal HIPAA Privacy Rule.

I have the right to revoke this authorization. My revocation of this authorization must be submitted in writing to Roy B. Blumenstrauch, M.D., except to the extent that the practice has already made disclosures and has acted in reliance upon my consent and this authorization.

Signed by: _____ _____

Signature of Patient or Legal Guardian | Relationship to Patient

_____ _____

Print Name of Patient | Date

_____

Print Name of Guardian