AUTHORIZATION FORM FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FROM MCCLURE MEDICAL PRACTICE

Instructions: All the Blocks 1-6 must be completed. If any block is not completed, then this "Authorization Form" will be considered incomplete and defective and cannot be used.

EMAIL THIS COMPLETED FORM TO: DOC@MCCLUREMD.COM

Allow 2 Weeks to Process

PLEASE PRINT ALL INFORMATION EXCEPT FOR REQUIRED SIGNATURES

Block 1: Identification of Patient

PATIENT NAME_____DATE OF BIRTH_____

PATIENT'S NAME USED WHILE A PATIENT OF MMP (if different) _____

Block 2: Type of Records/Information to be disclosed: Please describe what specific records/information may be used or disclosed. (examples: ALL, X-Rays only, records for the last 12 months….)

☐ ALL

☐ OTHER:

Block 3: Persons, Facility, or class of persons who are authorized to use or disclose (provide) the records/information: MCCLURE MEDICAL PRACTICE; SHELLEY MCCLURE, MD

Block 4: Persons, facility or class of persons who are authorized to receive the records/information:

Facility Name:
Address:

Phone Number:
Email

Block 5: Expiration: This "Authorization" will expire one week after transmission of the records.

Block 6: Authorizing Signature:

- I understand that if the person or entity that receives the described records/information is not a Health Care Provider or Health Plan covered by federal privacy regulations, the records/information may be redisclosed and no longer protected by those regulations.
- I may inspect or obtain a copy of any records/information used or disclosed under this authorization.
- I also understand that I may revoke this authorization at any time by delivering a written revocation.
- If I revoke this authorization it will have no effect on actions already taken on reliance of this form.
- I authorize the use or disclosure of the records/information described. I have read and understand this form. I am the patient listed or am authorized to act on behalf of the patient as the patient's personal representative.

_____ _____

Signature of Patient or Patient's Personal Representative Date of Signature

_____ _____

Personal Representative's Relationship to Patient Printed Name of Personal Representative